Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 12. Dete of Deeth

- 6					C	ertificate o	f Death		Reg. No.	U	1001
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•	amine		4e. Fecility Neme (If not institution, give	street end number)			4b. City, Town, or	Location of Death	4c. County	of Death	
			III Second St	reet		M Hadas 4 Va	Pocondo	e holi	Mon	esta	
Fune			5. Social Security Number 6. Se	X 7. Age (□M 2.00 F	(In yrs. last birthde I Or Yrs.	Months Dey			y, Year)	9. Birthple	ace (State or Foreign
Direc	tor		Usual Rasidance of Decedent	7				9-4	2-1/8	FIRM	/EXAS
death with the Marylend ms 23a or 28a-f show	10		10a. Stete 10b. County	, 1	Oc. City, Town or	Location	1	4		10	d. Inside City Limits
h the Marylen r 28a-f ehow	Illed	ctor	M) Worces	ter	POCOMO	Ke C	ity, N	1d.			1 Yes 2 No
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	Examiner must be	Funeral Director	11. Maritei Stetus	12. Wes Decedant Ev Armed Forces?		 Was Decedent of if Yes, specify Co 	f Hispanic Origin? (Suban, Mexicen, Puar	Specify Yes or No to Rican, etc.)	- 14. Rac Bied	e - Americe ck, Whita, e	
3 aft	Same	by F	1 Never Married 2 Merried 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates:		1□ Yes 2□M	lo Specify:		Specify	R	1-1
5-0020 72 hours after natural; or ite	180	bg	15. Decedent's Edu		16e. Dec	edant's Usual Occ	cupetion		16b. Kind of Br	usiness/Indu	19CK
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Maryland d 2 should be file th and Mentel Hy 7 is marked oth	any injury of other traumatic event, if a Monte.		19e. informant's Neme/Reletionship (T	ype, Print)	J 19b. Ma	illing Address (Stre	et end Number or R	0		State, Zip	- 1 -
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Baltimore, Nomit. Pages 1 and Department of Health mportant: If New 27	6		1 Burial 2 □ Cramation 3 □		cemetery, c	remetory or other p	oleca)	Date	~ 1 /	,	vn, State
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ing P		Certification:	27. Manner of Death ⊅⊠Natural 5 □ Panding	28e. Date of injury (Month, Dey Y	(ear) 28b. Time Injury	W		28d. Dascribe I	now injury occur	red	
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Division or Attending after death. Director: After	5	EL I	4 ☐ Homlcida determinad	28e. Plece of Injury building, etc. (Specify)	street, rectory, onto	×6	City or Tov	Street and Numb vn, Stete)	er or Hurei	Houte Number,
spital cours			29a. Certifier 1 Certifying Phy.	aiclan: To the best of n	ny knowledge de	eth occurred et tha	time dete end niace	e and due to the	reuse(s) and me	nner se eta	ated
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Division of when the Hospital or Attending Physwithin 24 hours after death. To the Funer of Director: After this commissivified in but the funeral	1	-	29b. Signature and title of certifier			29c. Lica	nsa number		29d. Dete signa		
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	6	>	PAUL FLEURY	3057	enth	57	10 COV	noke (ity	218	01
	Ctot		31. Dete filed (Month, Day, Year)	32 Registrer's	Signature						

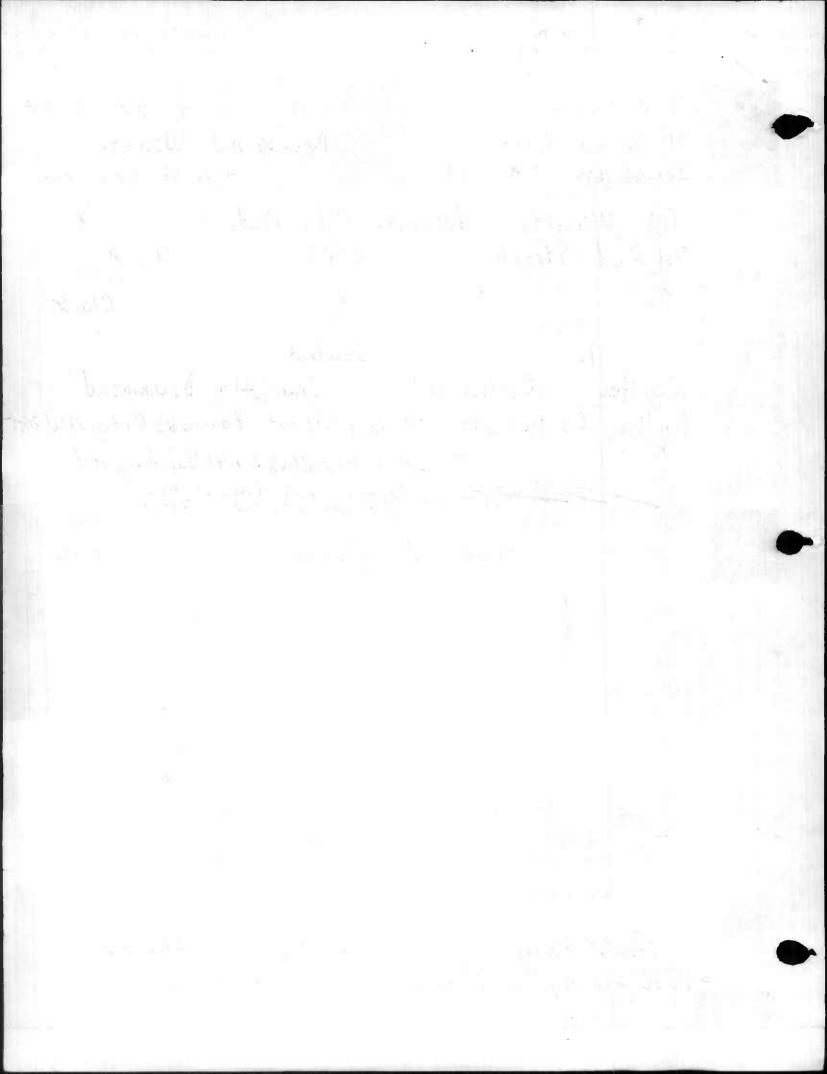
State Registrar

FEB U 9

FEB 0 9 1998 July Day

32. Registrer's Signature

June Davidson-Randala

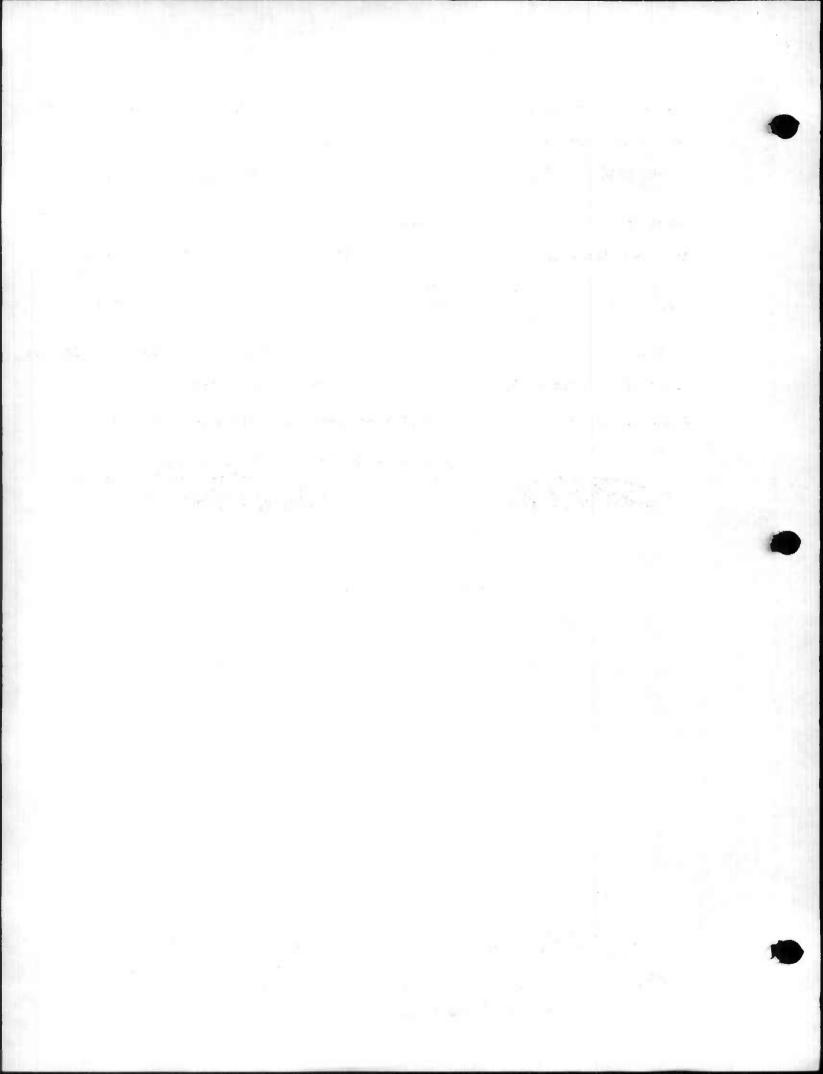


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Elmer A. Carroll, Jr. Feb. 18, 1998 3:00 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4h City Town or Location of Death 4c. County of Death Examiner Golden Age Guest Home Sykesville Carroll If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** XOM 20F Deys Yrs. Director 218-07-3956 79 May 21, 1918 Maryland Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Directo Maryland Carroll Westminster the 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1656 Sams Creek Rd. 21158 United States death Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 □ Yes 2 □ No 1941 — If Yes, Give Year or Detes: 1945 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours efter of Hygiene. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3√3√Widowed 4 □ Divorced Completed the Medical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12th Assistant Superintendent Delivery of Baltimore markad other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is merked other any injury or other traumatic event page. 17. Father's Name (First Middle Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Elmer Allen Carroll, Sr. Mary Ellen Jones 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Roger L. Carroll - Son 1656 Sams Creek Rd. Westminster, MD 21158 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Lorraine Park Cemetery Feb 21,98 Woodlawn, MD 21. Signeture of Funantial Earl 22. Name and Address of Fecility Burrier-Queen Funeral Home 1212 W, Old Liberty Rd.
Winfield, MD 21784

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliure. List only one cause on each line. Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final ulliano diseese or condition resulting in death) Examiner Due to (or es e consequenca of): Physician/Medical Examiner Sease alluscus The law requires that the death certificate be executed burial-transit Sequentietly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760. the Due to (or as e consequença of): 98 USB for P.O. 1 Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records, by 24b. Were eutopsy findings eveilable prior to page 2 should Completed 24a. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Restdence 6 ☐ Other (Specify) 2 1 Yes 2 No this 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) Certification: 28b. Time of 28c. tnjury et Work? 28d. Describe how Injury occurred After Division or Attending 1 PNeturel 5 Pending investigation 1 Yes 2 No within 24 hours efter death. To the Funeral Director: A the 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 4 Homicide .0 filled Hospital 1 Certifying Phyeiclan: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the ceuse(s) and menner stated. 29a. Certifier Medical completely (Check only one) g g 29b. Signature, and little of certifie 29c. License number 29d. Deje signed (Month, Dey, Yeer) musus 30. Nempand eddress of person who completed cause of deeth (Item 23e) (Type, Print) Liberty Rd Eldershung MD HATRICK TURNES UD 32. Registrar's Signeture 31. Date filed (Month, Day, Year) State FEB 1 9 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 12:25 PM **Physician** Fell 2 16 1958 cation of Deeth 4c. Country of Deeth /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Laurel Regional Hospital Prince George's Laure1 If Under 1 Yeer If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs 81 Feb. Director 579-18-9643 26. Texas 1916 Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow item 27 le marked other than "naturel", or Items 23a or 28a-f ehov other traumatic event, the Med cal Examiner must be nottled at 1 No 2 No Directo Maryland Prince George's Tuxedo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2409 57th Place 20785 U.S.A. deeth Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Stetus permit. Pages 1 and 2 should be filed within 72 hours efter Depertment of Health and Mental Hygiene. Important: If Item 27 le marked other than "naturel", or Item any Injury or other traumatic event, the Medical Example. 1 ☐ Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) 10 Secretary Lega1 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence Holman Kitty Pear1 Flowers 2 19e. Informent's Neme/Reletionship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Dorr - Husband 2409 57th Place, Tuxedo, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burlal 2 M Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 2/17/98 Alexandria, Virginia 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 0 20781 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart feliure. List only one cause on each line. Approximete Intervel Between **Physician** CerebroursenL /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Myo Examiner andla physicien end the burial-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Last Due to (or as e consequence of) P.O. Box 68760, Je8515 The law requires that the death certificate be Physician/Medical Due to (or es e consequence of) ettending p Pert II. Other significant conditions contributing to death out not resulting in the underlying cause given in Pert I detached 23b. Did tobacco use contribute to the cause of death? the signed by t 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 € Unknown Records, þ Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to peen completion of ceuse of deeth? has page 2 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Deeth (Check only one) exeminer? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Medical Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ SuicIde 6 Could not be 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) and menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and menner stated. 29e. Certifier 29b. Signature end title of certifie 29d. Date signed (Month, Dey, Year) 29c. License number 30. Neme end eddress 31. Dete filed (Month, Dey, Year) Registrer's Signature 32 State Registrar FEB 20199

and the same of th 98-0594-033 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene. CALVIN LEE Certificate of Death DILDY Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Physician CALVIN LEE DILDY 08 1998 4c. County of Death /Medical 4b. City, Town, or Location of Daath 01:03 AM 4a Facility Nama (If not institution, giva street and numbar) **Examiner** PRINCE GEORGES SILVER HILL ROAD AND BRANCH AVENUE SUITLAND If Undar 24 Hrs. If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Days 10XM 2□ F Yrs. Director APRIL 1, 1949 WASHINGTON, D.C. 577-66-2249 48 Usual Rasidanca of Dacedani with the Maryland 10a. Stata 10b. Count 10c. City. Town or Location 10d. Insida City Limits ahow r than "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at D.C. WASHINGTON 1 ¥Yas 2 □ No Director 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 4635 HILLSIDE RD. #3 S.E. 20019 UNITED STATES Funeral deeth 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Biack, Whita, atc. filed within 72 hours efter 1 Naver Married 2 Married 1 ☐ Yas 2 X No If Yas, Giva Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: BLACK 2 3 ☐ Widowed 4 X Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Hygiene. Coilaga (1-4or 5+) PRIVATE 12TH PORTER of the end Mentel Hygic 27 is marked other if traumetic event, 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be permit. Pages 1 end 2 should be incertained of Heelth end Mentel important: If Item 27 is marked or ALBERT DILDY AGNES RICHARD 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) TIRRELL DILDY/ DAUGHTER 855 XENIA ST. S.E. WASHINGTON, D.C. 20032 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 0 1 XBuriai 2 Cramation 3 Ramovai from Stata HARMONY MEMORIAL PARK 2/14/98 LANDOVER, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE/FORESTVILLE, MD. M1085 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner physician and the buriel-tran Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes þ Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy peen completion of causa of daath? Yas Yas 2 No certificate Division of Vital director, Be 25. Was case referred to medical 26. Placa of Death (Check only ona) axaminar? Other: 4 Nursing Homa 5 Residence 6 Nother (Specify) SCENE Yas 2□ No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month, Day Year) Certification: 27. Mannar of Death 28b. Tima of Dascribe how Injury occurred 28c. Injury at Work? 28d Injury 1 DNaturai 5 Panding 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) efter deeth. Director: Af 1 Yas iver in auto o-cite 2 Accidant invastigation (Street 3 ☐ Suicida 6 Could not be datamined 28f. and Number or Rural Routa Number 4 Homicida 6 29a. Cartifier (Check only Medical 1 Cartifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and man pletely that and place, and thus to the cause(s) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, and manner stated. onel To the Vithin 2 29c. Licansa number 50 FEBRUARY 08, 1998 OCME

Registrar

LOCKE

and address of person who completed cause of death (Item 23a) (Type, Print) MO

111 Penn Street, Baltimore, Maryland 21201

32 Registrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Day **Physician** Month 10:00 p.m. Algeria L. 13, 1998 Dieguez February /Medical 4e. Fecility Name (If not institution, give street end number) 4h City Town or Location of Deeth 4c. County of Deeth Examiner 4512 Tuckerman Street Riverdale Prince George's If Under 24 Hrs. Hours Min. 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthdey) Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 1 ■ M 2 🖾 F Deys Yrs. Director 215-62-3364 Aug. 10, 1920 Guatemala Usual Residence of Decedent 72 hours after death with the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show 1 Ves 2 No Director Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4512 Tuckerman Street U.S.A. 20737 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 N Yes 2 No Specify: Guatemalan þ 3 ☐ Widowed 4 ☐ Divorced Specity: Hispanic Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health end Mental Hygiene. Important: if Itam 27 is marked other than "na any Injury or other traumatic event, ins Wedge. (Specify only highest rede completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Angel Morales Amelia Aguilar Reyna 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Luis F. Dieguez - Spouse 4512 Tuckerman Street, Riverdale, Maryland 20737 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ABuriel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) G. Washington Cemetery 02/16/98 Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Feculity
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between **Physiclan** /Medical Immediete Ceuse (Finel MUS disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac OBSTRUCTION 1 Yes 20 No 3 Probably 4 Unknown þ Completed 24e. Was en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? certificate has 20 No 1 Tyes 1 ☐ Yes 2 No or Attending Physician: Be 25. Wes cese referred to medicei 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes After this 27. Meaner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation within 24 hours after deeth.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 4 Homicide the Hospital 12 certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. edical 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature end little of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 2

State Registrar 30. Neme end edd

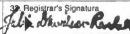
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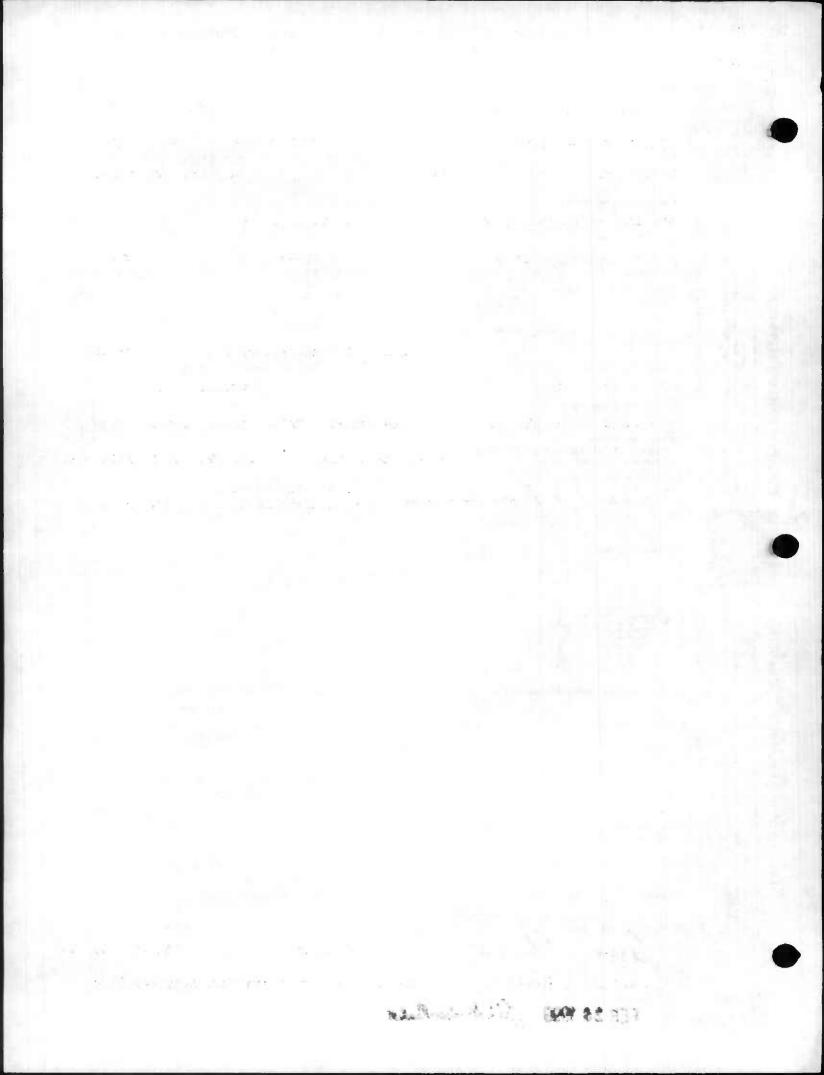
32. Begistrer's Signature

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Registrar





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month 30 AM 9 PAUL RICHARD DAYE, SR. /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** Worcester Atlantic General Hospital Berlin If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthpleca (State or Foreign Country) **Funeral** 1**X**) M 2□ F Deys Yrs. MD 213-22-9214 Director 67 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be nothed at MD Worcester Berlin 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21811 11723 Grays Corner RD Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 (※No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. 11. Meritel Stetus filed within 72 hours efter Hygiene. 1 Never Merried 2K Married 1 Yes 2 XNo Specify: þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. mt. If tem 27 is marked other than Elementery/Secondery (0-12) College (1-4or 5+) Truck Driver Oil Co. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Hallie Quillen Frank Daye 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11723 Grays Corner RD Berlin, MD 21811 Reba Daye/ Wife 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1₺ Buriel 2-□ Cremetion 3 □ Removel from State Sunset Memorial Park 2/17/98 Berlin, MD 5 Other (Specify) 21. Signature of Funeral Se 22. Neme end Address of Fecility Burbage Funeral Home 108 William St. Berlin, MD 21811 ne dialn. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximete Interval Between Onset and Death **Physician** /Medical fmmediate Ceuse (Finel CZN CLI 3 48215 disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest attending physician end for use es the buriel-tran Due to (or es a consequence of): Physiclan/Medical Due to (or es e consequence of): Pert fi. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? herit ate has been signed by page 2 should be detact 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No this certificate Be 25. Wes cese referred to medical examiner? 26. Pleca of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2₺ No 1 Inpetient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 26a. Dete of fnjury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending Investigation 1 Meturel To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: Al completely filled in by the fu 1 Yes 2 No death. 2 Accident 3 Suicide 8 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) and menner as steted. 29e. Certifier Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one)

Records, P.O. Box 68760, of Vital Attending

PAUl Daye Sr

the Maryland

State Registrar

FEB 1

29b. Signature and title of certifier

31. Dete filed (Month, Day, Year)

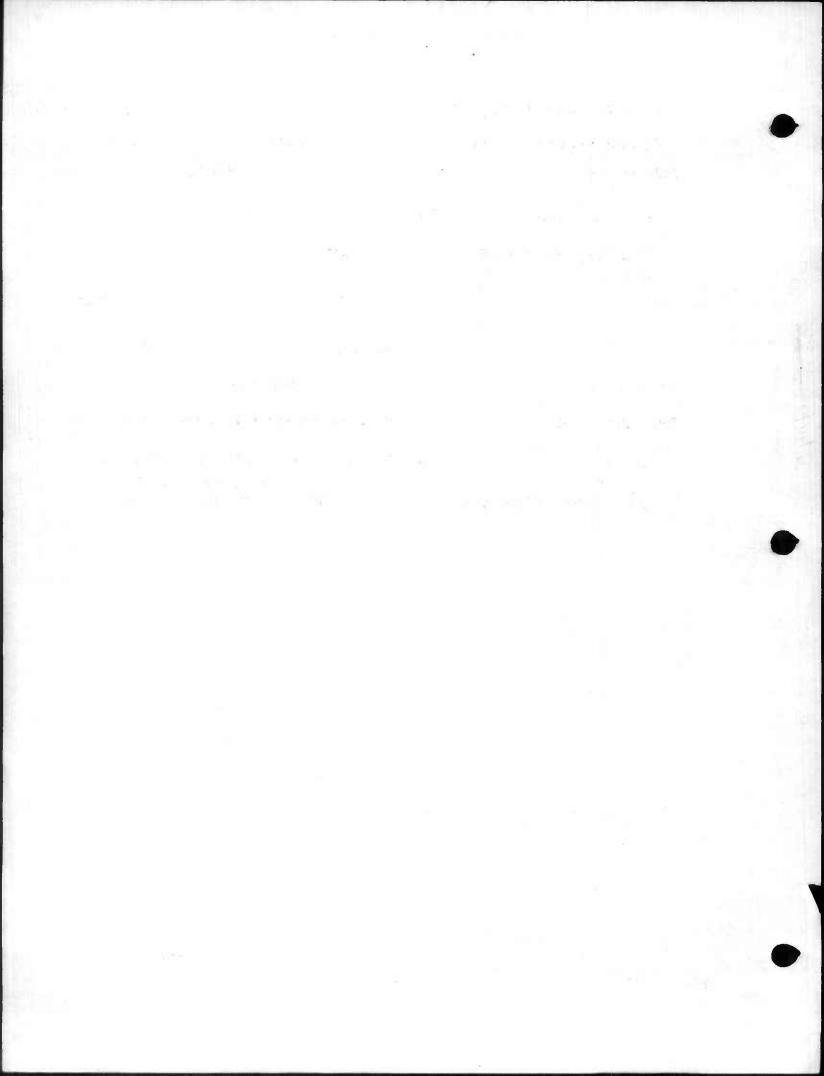
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30. Name and eddress of person who completed cause of death (item 23a) (Type, Print) 32. Registrer's Signeture July Davidson-Randall

29c. License number

29d. Dete signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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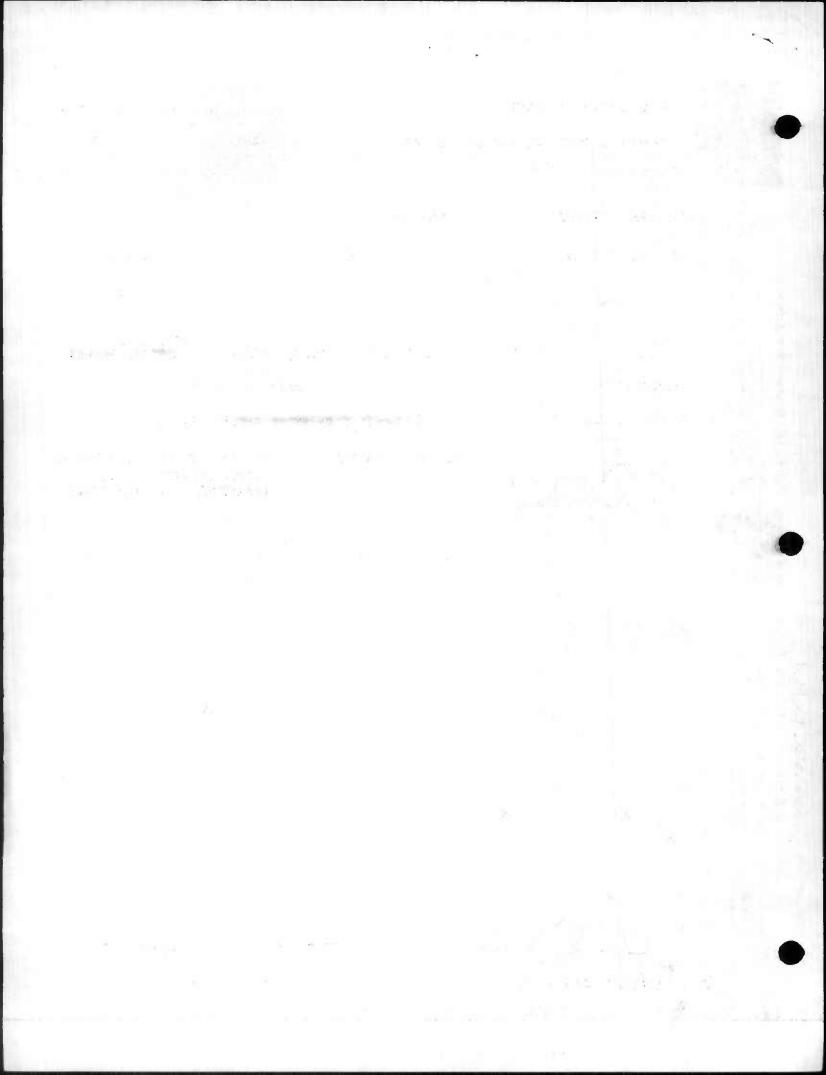
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State of Maryland / Department of Health and Mental Hygiene ()

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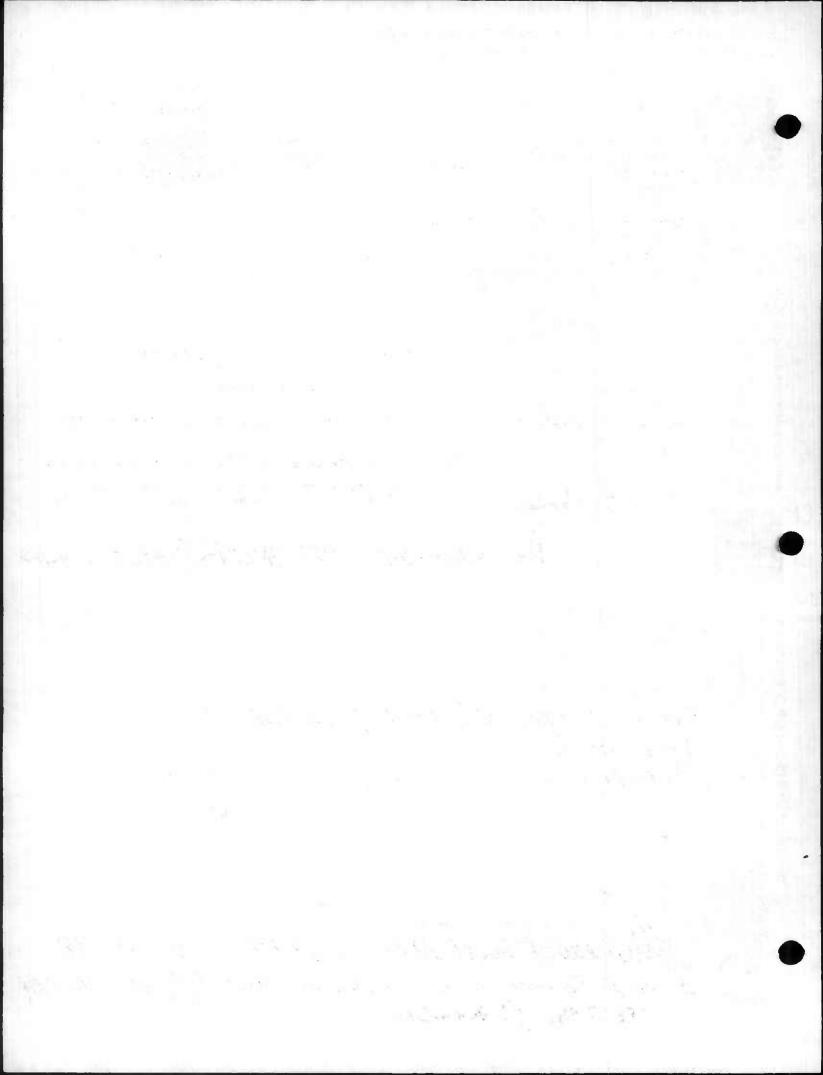
State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 98 0701

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	Physic /Medi		Jessie A. F	Lorimbio				Februa		
	Exami		4a. Facility Nama (If not institution, giva	street and number)			4b. City, Town, or L	ocation of Death	4c. County of De	ath
			9242 Annapolis Roa	ad			Lanham		Prince (George's
	Funeral		5. Social Security Number 6. Sa	TM ONE	yrs. last birth	Months Days		8. Data of Birt	y, Year) 9. B	rthplaca (Stata or Foreign
-	Director	Н.	719-10-3914	3 × 2 × × × × × × × × × × × × × × × × ×	4 Yı	S.		April 1	.2, 1913 Wa	shington, DC
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_		F	1 ☐ Navar Marriad 2 ☐ Married	Armed Forces? 1 ☐ Yas 2 ☒ No	0,0.	13. Was Decedant of If Yas, specify Cul		Rican, atc.)	Black, Wh	
Maryland 21215-0020	72 hours after death with the Meryler naturel, or lems 23e or 28e4 show acel Examiner must be notified at	by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	If Yas, Giva Yaar or Datas:		1□ Yas 21 No	Specify:		Specify:	White
9	2 hou	pe	15. Dacadant's Edu		16a. D	ecedant's Usual Occu	pation		16b. Kind of Businas	s/Industry
215	hin 7	Completed	(Specify only highast grad Elementery/Secondary (0-12)	a complatad) College (1-4or 5+)	(1	Giva kind of work done ifa. DO NOT usa ratire	during most of work	ing		
21	d wit	mo:	9	College (1-401 5+)	Hon	nemaker			Own Home	
pu	office of the vent	Bec	17. Fathar's Nama (First, Middla, Last)				18. Mothar's Nam	a (First, Middla,	Maidan Sumama)	
<u>a</u>	Aente Aente rked tice	TOE	Louis Lippincott				Alice Os	bourne		
an	am a		19a. Informant's Neme/Ralationship (T)	rpe, Print)	19b. N	Meiling Address (Stree	t end Number or Rur	al Routa Numba	r, City or Town, Stata,	Zip Coda)
	and 2 27 is		Robert A. Florimbi	o - Son	691	3 Saint Ar	nne's Aven	ue, Lan	ham, Maryl	and 20706
Baitimore,	permit. Peges 1 and 2 should be filed within 72 hours Department of Health end Mental Hygiene. Immortant: If item 27 is marked other than "natural; any follury or other traumatic event, the Medical Examples.		20a. Mathod of Disposition		b. Place of D	isposition (Neme of cramatory or other pla	ace)	Data	20c. Location - City of	r Town, Stata
Ĕ	Peges nent of h int: If he iry or of		1 ☑ Burial 2 ☐ Cramation 3 ☐ F 4 ☐ Donation 5 ☐ Othar (Specify)		-	incoln Cem		17/98	Brentwood	Marvland
ait	Departit. Departit Importa		21. Signatura of Funarai Sarvice Licens			22. Nama and Addr	ass of Facility			
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			23a. Part1. Entar tha disaasa, or compl shock, or haart failura. List only or	ications that caused the	daath. Do no					Approximate Interval Batween
м	Physician			Λ						Onset and Death
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	Examiner		resulting In death)	Dua	lo (or as a co	nsequenca of):	TEMPLONIA	W W I	0 1210	= wyen
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	death certificete be executed e ettending physician end ed for use as the burial-transit	Examiner	Saquantially list conditions,	Due 1	lo (or as a co	nsequence of):				
Ö,	e ex		Saquantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury							
68760,	ete b hysic the b	edical	that Initiated events rasulting in death) Last	Dua t	o (or as a co	nsequence of):				
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Box	thet the death cen ed by the ettendin detached for use	lan								
0	0 0 2	Physician/	Part II. Other eignificant conditions con	tributing to death but not	rasulting In t	ha undarlying cause g	iven In Part I.	23b. Did t	obacco usa contribu	ta to the cause of death?
4	requires that the sen signed by th hould be detache		CHRONIE NESTA	TUCTUEF	SIMO	NAAY 3	DICEAGE	10/	res 2□ No 3□	Probably 4 Unknown
Records,	8 50	b	11 NOTATION OF THE	cocior i	OH III	117	1661116		1	
9	v require been si should	etec	TNEUMANIA					24a. Was a		. Wara autopsy findings available prior to completion of cause
Sec	S S	Completed	10101			-				of death?
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Vita	ystcian: The is s certificate he director, page	Be	25. Was case rafarred to medical axaminar?	- 70		77	26. Placa of Deet	h (Check only o	na)	
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	ding P. After funer	Certification:	27. Manner of Death 1 □ Natural 5 □ Panding	28a. Data of Injury (Month, Dey Yea	r) 28b. Tin	iry Wo		28d. Dascribe h	ow injury occurred	
Si	Attending or death.	cat	2 Accidant invastigation 3 Sulcida 6 Could not be]Yas 2□No			
Division	or Attendi	T T	4 ☐ Homicida determined	28a. Plece of Injury - / building, etc. (Sp		i, straat, factory, offica		City or Tow	itreet end Number or I n, Stete)	Hufai Houta Number,
_	To the Hospital or Attending Phywithin 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral		29a. Certifilar 1 Cartifying Phys	dalas Tarkakan dari						
	To the Hospital within 24 hours. To the Funeral completely filled	edical	(Check only one)	elclan: To the best of my ner: On the basis of exam end manner stated.	nination and/	or invastigetion, in my	ima, deta and piaca, opinion, deeth occuri	ed at tha tima, o	euse(s) end mannar i data and placa, and du	is stated. le to tha cause(s)
	o the o the omple	M	29b. Signature and title of certifier	eno marriar stateo.	71	29c. Lican	sa numbar		29d. Deta signad (Mor	nth. Dav. Year)
	F \$ F 8		MII. W. 1.18	10010	All	A DI	1001	7	7-111	-00
	F		20 Name and address	yourse	Mel	01/	6071		2-14	70
	(5)		30. Nema and address of person who co	mpiated causa of death (Itam 23a) (T)	(pe, Print)	1/=1/10	ONII	SAL MADE	LANT DATE
17	1	100	31. Data filed (Mortiff, Day, Yaar)	32 Ragistrar's S	2/01 (35th HVE	1 VICE CHR	ROLLT	ON WHAY	184 00,000
	Sta Registr	000	FEB 17 1998	Sale Dr. and	see Real				/	,
100				William St. And St. Co.	A A A A A A A A A A A A A A A A A A A	pa sily				



State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death

Physiclar	1
/Medica	ı
Examine	r

3. Time of Death

6:30 AM

Funeral Director

with the Maryland 28a-f show 6 234 filed within 72 hours efter death

Director

Funeral

PV

Completed

Be

10

the Medical Examiner must be notified at Hems. ò "natural", other than

Baltimore, Maryland 21215-0020 parmit. Peges 1 and 2 should be filk Department of Health and Mentel Hy Important: if Item 27 is marked oth any linury or other traumatic event 2008.

Physician /Medical Examiner

Box 68760.

P.O.

Division of Vital Records.

Physician/Medical Examiner use as the burial-trensit and ettanding physician the signed by þ Completed peen certificate has director, Be Certification: To this funeral the 3 edical

The law requires that the death certificate be executed Attending Physician: i or Attending Pt efter death. Director: After th To the Hospital within 24 hours or To the Funeral I

1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day ROBERT EUGENE FRAYSIER FEBRUARY 14, 1998 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death ROCKVILLE NURSING HOME ROCKVILLE MONTGOMERY COUNTY If Under 1 Year 5. Social Security Number If Undar 24 Hrs. 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Days Months Hours Yrs. 578-03-2471 84 DEC. 25, 1913 VIRGINIA Usual Rasidance of Decedant 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 ☐ Yas 2 No MARYLAND MONTGOMERY COUNTY ROCKVILLE 10e. Street and Number 10f. Zip Coda 10g. CitIzan of What Country? 625 WEST LYNFIELD DRIVE 20850 UNITED STATES 12. Was Decedant Evar in U,S. Armed Forcas? 1 X Yas 2 ☐ No 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritai Status 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Nevar Married 2 ☑ Married 1 ☐ Yas 2 X No Specify: Specify: 3 Widowed 4 Divorced WHITE Yaar or Datas: 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 GLAZIER ARCHITECTURE 17. Father'a Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) BERNARD L. FRAYSIER LULA VAUGHAN 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) MARGARET FRAYSIER, WIFE 625 WEST LYNFIELD DRIVE, ROCKVILLE, MD 20850 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Buriai 2 X Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) FORT LINCOLN CREMATORY 2/17/98 BRENTWOOD, MARYLAND 22. Nama and Addrass of Facility FORT LINCOLN FUNERAL HOME ours (D. Wran 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximeta intarval Batween Onsat and Death immediata Causa (Finel disaasa or condition resulting in daath) CARCINOMA STOMACH 6 MONTHS Dua to (or as a consequence of): Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Dua to (or as a consequanca of): Dua to (or as a consequence of) rasulting In death) Last Part ii. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the cause of death? CANCER PROSTATE 24e. Was an autopsy performed?

1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findinga available prior to completion of causa of daath? 1 ☐ Yas 2 No 1 ☐ Yas 2 X No

25. Was casa rafarrad to medical axaminar? 1 Yes 2 No

27. Mennar of Death

1 X Naturai

2 Accident

3 Suicida

oon).

4 Homlcida

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of injury (Month, Day Year) 5 Panding invastigation

28b. Tima of

28a. Place of injury - At home, farm, streat, factory, office building, atc. (Spacify)

Other: 4 X Nursing Homa 28c. injury at Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

26. Placa of Death (Check only ona)

28d. Dascribe how injury occurred

5 Rasidance 6 Othar (Specify)

29a. Certifian (Check only

6 Could not be datarmined

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. n the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) in the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) in the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) in the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) in the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) in the basis of axamination and/or invastigation. 29c. Licansa number 29d. Data signed (Month, Day, Year)

29b. Signature and title of senting me

D07471

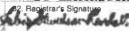
FEBRUARY 14, 1998

30. Nema and addrass of person who concleted causa of death (item 23a) (Type, Print)

PAUL NOONE, M.D., 50 WEST EDMONSTON DRIVE, #207, ROCKVILLE, MARYLAND 20850

31. Data filad (Month, Day, Year)

FEB 18 1998



State

Registrar

the Holes Some

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ACT 3 (437

KINES, New S. M.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Deta of Deeth **Physician** February Gertrude Dryden Figgs /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In vrs. lest birthday) Birthplece (Steta or Foreign Country) **Funeral** 1 □ M 2 1 1 F Yrs. Director 219-14-4180 92 Sept.14,1905 Md. Usual Residence of Decedent the Maryland 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Exampler must be notified at 1 ☐ Yas 2 ☐ No Director Md. Worcester Snow Hill 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21863 3528 Sand Road Funeral U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Dates: 14. Race - American Indien, Bleck, White, etc. Wes Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status filed within 72 hours after 1 Naver Married 2 Married 21215-0020 1 Yes 2 No Specify: by Specify: white 3 Widowed 4 □ Divorced Completed 15. Dacedent's Education (Specify only highest grede complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) pernit. Pages 1 and 2 should be filed within Deportment of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementery/Secondary (0-12) College (1-4or 5+) seamstress sewing factory Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Edward Dryden 2 Mary Frances Burke 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Linda Figgs 3769 Sand Rd., Snow Hill, Md. 21863 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete Burial 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) Mt. Olive Cemetery 2/13/98 Snow Hill, Md. 21. Signatura Funeral Service Licensee 22. Name end Addrass of Fecility P.O. Box 87 - Klemus Dennis Funeral Home, Snow Hill, MD. 21863 23a. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failura. List only one cause on each line. Approximate Interval Between Onset end Daath Physician /Medicai Immediate Cause (Final disaase or condition resulting In deeth) ACUTE LEUKEMIA. **Examiner** Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MY DUEASE Division of Vital Records, b 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? page 2 should Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) P 1□ Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 8 27. Manner of Deeth Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No To the Hospital or Atlandi within 24 hours after death To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29a. Certifier Medical

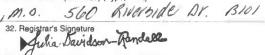
6 State Registrar

31. Date filed (Month, Day, Year) FEB 1 3 1998

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(Check only one)

29b. Signeture end title of condition

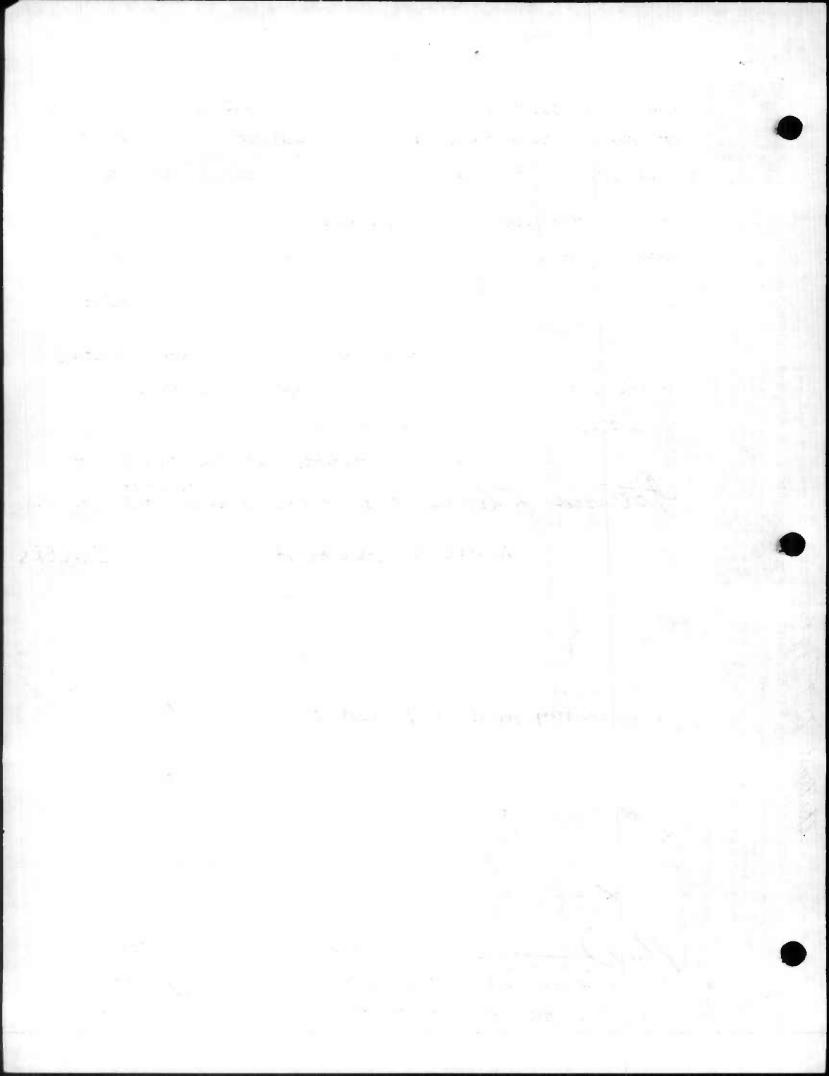


person who completed cause of deeth (Item 23a) (Type, Print)

29c. Licansa number

29d. Data signed (Month, Dey, Year)

SALISBUTY,



State of Maryland / Department of Health and Mental Hygiene

				Certificate of Death	Reg. No.
	Physic		1. Decedant's Name (First, Middla, Last)	2. Data of Month	
	/Medi		John F. Godfrey, Jr.	Febru	
	Examir		4e. Facility Name (If not institution, giva street and number)	4b. City, Town, or Location of D	
			Southern Maryland Hospital Cent		Prince George's
	Funeral		5. Sociel Security Number 6. Sax 7. Aga (In yrs. le.	Months Devs Hours Min. (Month.	Birth Day, Year) 9. Birthplace (Stata or Foreign Country)
	Director		055-18-6155 73 Usuai Residance of Decedant	Marc	h 24,1924 New Jersey
	fand fand			Town or Location	10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show mast be notified at	ţ	Maryland Prince George's Di	strict Heights	1 Yas 2 No
	r 28a-f	rec	10e. Street end Number	10f. Zip Coda	10g. Citizan of Whet Country?
	th with 23a or	i i	6909 Kipling Parkway	20747	U.S.A.
	death	Funeral Director	11. Marital Stetus 12. Wes Decedant Evar In U.S.	. 13. Was Dacedent of Hispanic Origin? (Specify Yas or If Yas, specify Cuban, Maxicen, Puarto Ricen, etc.)	
21215-0020	72 hours after neturs!, or ite	þ	1 Nevar Merried 2 Married 3 Widowad 4 Divorced Armed Forces? 1. Yas 2 No 42-4 Yas, Giva Yas, Giva Yas, Giva Yar or Dates:	If Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 1 ☐ Yas 2 ☐ No Spacify:	Bieck, White, atc. Specify: White
2-0	72 hours "naturs!",	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedant's Usual Occupation	16b. Kind of Businass/Industry
	C	npie		16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	
21	ygien t, th	S	4	Building Management	Federal Government
pu	d off	Be	17. Father's Nama (First, Middla, Last)	18. Mothar's Name (First, Mid	dla, Maidan Sumema)
Maryland	d 2 should be filed within th and Mantal Hygiena. 7 Is marked other than traumatic event, the Mantal traumatic event eve	2	John F. Godfrey	Dorothy F. I	Davis
Na Na	2 sh and Is m		19a. Informent's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Straat and Number or Rural Routa Nu	
	ges 1 and 2 should be filed withi t of Haalth and Mantal Hygiena. If Item 27 is marked other than or other traumatic event, the M			6909 Kipling Pkway, District	
Baltimore,	permit. Pages 1 and 2 Department of Health is Important: If item 27 is any injury or other tra once.		1 Burial 2 Cramation 3 Removat from State	ce of Disposition (Nama of natary, crametory or other place)	20c. Location - City or Town, Stata
i i	it. Parturant		4 □ Donation 5 □ Other (Spacify) 21. Signature of Funaral Sarvice Licansa	opolitan Crematory 2/16/98	Alexandria, Va.
Ba	permit. F Departm Importar any Injur		21. Signature of Funaral Sarvice Licansa	22. Name end Addrass of Facility George P. Kalas Funeral	Home
			Herege & Kalas	6160 Oxon Hill Rd Oxon	Hill. Md. 20745
			23a. Part1. Enter the disease, or complication, that ceused the deeth. shock, or heart father. List only one cause or each line.	Do not anter the moda of dying, such es cerdiac or respiretor	y arrest, Approximate Intarval Between Onsat and Deeth
	Physician /Medical Examiner	er	Immadiate Ceusa (Final disassa or condition rasulting in daath) a. Prumoj Dua to (or e	rung Embolism	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Year BEATRICE FEB. 10, 1998 1:20AM /Medical 4a. Fecility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Deeth **Examiner** PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Yeer 8. Date of Birth (Month, Dey, Yeer) 9. Birthpleca (State or Foreign Country)
SEPT.22,1921 GREENSBORO, NC If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2K F Days 76 Yrs. Director 579-28-3450 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1 N Yas 2 No Director N/A N/A WASHINGTON, DC 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ Herns 23a 2801 14th ST. NW #416 20009 USA Funeral 12. Wes Decedant Evar in U,S. Armed Forces? Wes Decadent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bieck, White, etc. 11. Maritel Status 1 ☐ Yes 2X No If Yes, Give Yaar or Detes: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 ŏ 1 ☐ Yes 2X No Specify: BLACK p Specify: 3 Widowed 4 Divorced "naturel". Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry permit. Pagas I and 2 should be filed withit Department of Haalth and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumetic. Elementery/Secondery (0-12) College (1-4or 5+) 9th BOOKBINDER GSA(FEDERAL GOVT.) 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Meidan Sumama) Be ROBERT GILL JESSIE HANNA 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) RONALD JOHNSON/ NEPHEW 207 POST OAK CT. LANDOVER, MARYLAND 20b. Piece of Disposition (Name of cematary, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removei from State 2-19-98 SUITLAND, MD 4 ☐ Donetion 5 ☐ Other (Specify) LINCOLN MEMORIAL CEM. 21. Signature of Funerel Servica Licansee 22. Name and Addrass of Facility
MARSHALL'S FUNERAL HOME OF MD COM 4308 SUITLAND RD. SUITLAND, MD 23e. Pert1. Entar the diseesa, or complications that causad the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner The lew requires that the death certificate be executed buriel-transit Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Box 68760 physician Physician/Medical tha Due to (or es e consequença of): use as P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 dnknown Records, þ 8 24b. Were autopsy findings aveilable prior fo completion of cause of death? Be Completed 24e. Wes an eutopsy performed? peed cata hes t 2 No 1 ☐ Yes 2 ☐ No cartificata Division of Vital or Attending Physician: 25. Was case referred to medical exeminer? 26. Piece of Death (Check only one) 3 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpetient 3 DOA Certification: To 1 Inpatient this 27. Menne of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Aftar 1 Neturei 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All complataly filled in by the further the funeral complatals filled in by the further the funeral filled in by the further furthe daath. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the tima, dete end piece, and due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and pieca, end due to the cause(s) end menner steted. 29a. Certifier Medicai (Check only 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 12 30. Name and eddress of person who completed cause of deeth (Item 23e) (Typa, Print) 7610 CARROLL AVE, TAROMA PARK, MARYLAND MOBARAK 31. Date filed (Month, Dey, Year) Registrar's Signature

John Develor Re

DHMH 16 Rev 6/95

State

Registrar

FEB 18 **1998**

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day 1998 4c. County of Death Month Physician JATTHER 2: 33 A.m. RNESTINE February /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath **Examiner** HOSPITAL CLINTON

inthday) If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth
Months Days Hours Min. 6/10/26 PRINCE GEORGES MARYLAND SOUTHERI 9. Birthplaca (Stata or Foraign Country)
Maryland 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F 71 Director 154-22-1979 Usual Residence of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ral', or items 23a or 28a-f show Examiner must be notified at Md. P.G. Forestville 1 ☐ Yas 2 ☐ No Director 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? with 5026 Silver Hill Ct. 103 20746 U.S.A. deeth Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 72 hours after 1 Nevar Marriad 2 Married 1 ☐ Yas 21 No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify þ Specify: Black 3 Widowad 4 □ Divorced "natural" permit. Pages 1 and 2 should be filed within 72 hr. Department of Heelth and Mental Hygiena. Important: If Item 27 Is marked other than "naturany injury or other treumatic event, "ne Med call once. Completed Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 11th Domestic Private Industry 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Ernest Green Emma Garnett 19e. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Arlene C. Taylor/Sister 2518 Darel Dr. #102, Suitland, Md. 20b. Place of Disposition (Nama of commutary, crematory or other place)
Harmony Mem. Park 2/26/98 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvica Licansaa 22. Nama and Address of Facility H.S.Washington & Sons Co, Inc. 4925 Burroughs Ave., N.E. Jany W. Crat 23a. Part1. Entar the disease, or complications that caused the deeth. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Batwe Onsat and Death **Physician** /Medical Immediata Causa (Final · GASTROINTESTINAL BLEEDING disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of): Examiner a consequance of): leeding sician and burial-transit The law requires that the death certificate be asscuted Saquantially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated avants resulting In daath) Last physician s the burial P.O. Box 68760. Physician/Medical Dua to (or as a consequance of) 98 980 pertension datached for Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, à director, page 2 should be Be Completed 24a. Was an eutopsy performed? Wara autopsy findings available prior to complation of cause of death? has 1 Yas 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Wes casa rafarred to medical 26. Placa of Death (Check only ona) Hospitel: 1 Inpatiant Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred After 1 Naturel 5 Pending 1 ☐ Yas 2 ☐ No 24 hours after death. 2 Accidant invastigation 3 Sulcida 6 Could not ba detarmined 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 4 Homloida 12 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and place, and due to the ceuse(s) and mannar es stated.
2 Medicat Examiner: On tha basis of axamination and/or invastigation, in my opinion, deeth occurred et the tima, data and place, end due to the cause(s) end mannar stated. 29a. Cartifian To the Hosp within 24 hou To the Fune completely fi 29b. Signatura and ma of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) D0051206

State Registrar

.1808 IV. QUIND Str. FILL Arlington. VA 22209 HLBEYIN DOGAN 32 Aggistrats Signatura

30. Nama and address of person who completed causa of daath (Itam 23a) (Type, Print)

THE RESERVE OF THE PARTY OF THE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month RUTH A. HAMAN GOVE 19,1998 6:20am February /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Pat Schuyler Domiciliary Sudlersville Kent 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9 - 20 - 1914 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1 □ M 2 □ X F Yrs. 83 Director 221-32-9013 Delaware Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at Middletown 1 ☐ Yes 2 No Delaware New Castle Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? death with 19709 4564 Summit Bridge Rd. USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Raca - American Indien, Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after to Dapartment of Haalth end Mental Hygiena. Insportant: If them 27 is merked other than "natural", or fren any Injury or other traumatic event 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Amanda Hester Coffin David James Smith 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Furel Route Number, City or Town, State, Zip Code)
4564 Summit Bridge, Middletown, DE. 19709 Alice Deats 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlel 2 ☐ Cremetion 3 ☐ Removel from State St. Georges Cemetery 2-23-98 St. Georges, DE. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility
DANIELS & HUTCHISON FUNERAL HOME 212 N. Broad St., Middletown, DE. 23e. Pert1. Enter the disease, or complications the profits the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only not a complications the profits the death. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel CArcio Resp Avest diseese or condition resulting in death) Examiner CAD3 & Diprrhythmia. & ValudarD3 certificate be axecuted bunal-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest and Box 68760. ettending physician Physician/Medical Due to (or es e consequence of) use es the P.O. 1 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Osteo porosis/ Osteo Arthuitis 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy The law certificate has 1 ☐ Yes 2€3No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Aftar this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28c. Injury et Work? 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: XXVetural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) end manner steted. Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 2/23/98

State

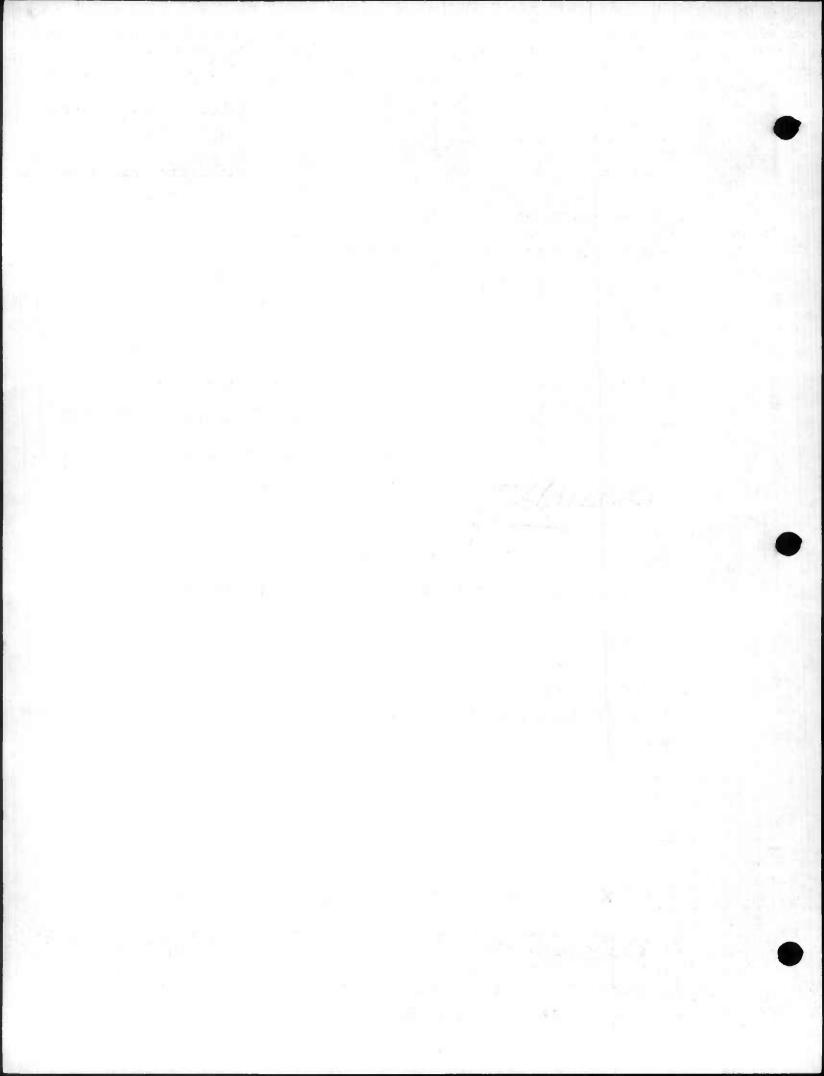
DR. Stoddard 31. Date filed (Month, Day, Yeer) Stoddard, 100 Brown Street, Chestertown, MD. 32. Registrer's Signature

FEB 23 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

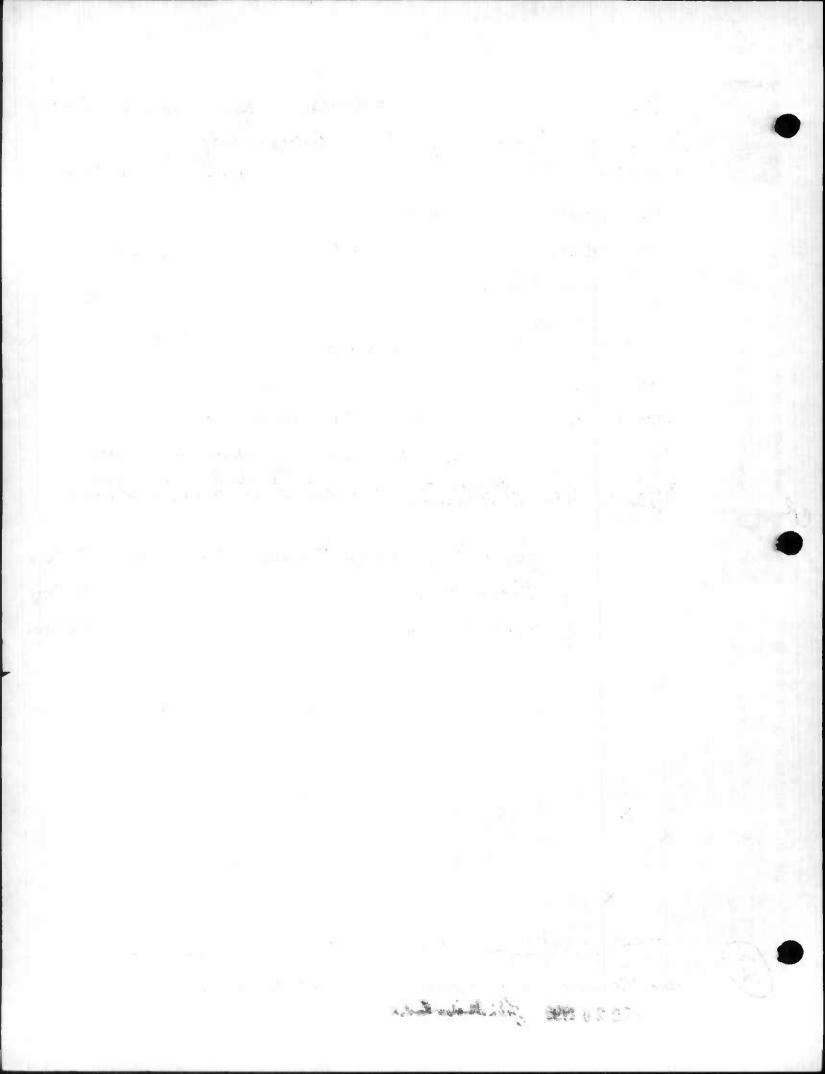
cha Davidson

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medical					Certi	ficate of	Death		Reg. No. 98	07019
		1. Decedent's Name (First, Middle, L	ast)			120.00	0	2. Dete of De	eth Dev	3. Time of Deeth
Micaical	ı -	ZXED			/	HAMI		Februa		998 18:43
Examiner	r	4e. Fecility Neme (If not institution, gi	ve street and number)	11.			4b. City, Town, or	Location of Deet	4c. County	of Deeth
		5. Social Security Number 6.	70 PK 1 7. Ao	1105	pital	Under 1 Year	DAHI M	ore City		
Funeral Director			Sex ₹ 7. Ag	e (In yrs. ill. 43		lonths Deys				9. Birthplace (State or Foreig Country) Bangladesh
ms 23a or 28a-f show r.must be notified at		VA. 10b. County FAIRFA	X		Town or Locet RTON	ion				10d. Inside City Limits 1 ☐ Yes 2 No
r tems 23s or 28s-4 show		10e. Street end Number 7440 LARNE LA	•			10f. Zip Code 22079)		10g. Citizen of W Bangla	
F. F.	2	11. Maritel Status 1 Never Married 2K Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Yeer or Dates:		If Ye	Decedent of les, specify Cub	Hispanic Origin? (pan, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		e - American Indien, k, White, etc. : Asian
ted for		15. Decedent's E (Specify only highest gi	ducation		16a. Deceden	's Usuel Occu	petion during most of wo	ndkina	16b. Kind of Bu	siness/Industry
ygiene. her than "natur t, the Wed call		Elementery/Secondery (0-12)	College (1-4or 5	+)	life. DO	TAURAN1	ed)	nking	FOOD	
is marked other than "netural", is marked other than "netural", raumatic event, the Medical Exa	3	17. Fether's Neme <i>(First, Middle, Les</i> HAIDER ALI	1)				18. Mother's Na AMINA	me (First, Middle KHATUI		θ)
or other traumatic event, the Medical or other traumatic event, the Medical To Be Completed		19e. Informant's Neme/Reletionship JAHRA F. HAMID	(Type, Print)				t and Number or Fi Lorton , V			Stete, Zip Code)
Department of Health of Important: If Item 27 is any injury or other tra	1	20e. Method of Disposition 1 ☐ Buriei 2 ☐ Cremetion 3 [4 ☐ Donetion 5 ☐ Other (Special Content of the cont		cer	ce of Disposition metery, cremeto MUSLIM	ory or other pla	ERY	Dete 2-20-98	STAFFO	City or Town, Stete
Departrumporta any inju		21. Supply Funeral Service Lice	insee Ma	to-			ess of Fecility Un nedy St, N			Y INC. D.C. 20011
hysician		23e. Pent. Enter the disease, or conshock, or heart feilure. List only	nplications that ceused y one ceuse on each lin	the death.	Do not enter to	ne mode of dyi	ing, such es cerdie	ec or respiretory e	rrest,	Approximete Intervel Between Onset end Deeth
Medical xaminer		Immediete Ceuse (Final diseese or condition resulting in deeth)	· ADULT	RE:	SPIRAT	TORY	DISTRES	55 S>	NDROM	E 20 doug 30 doug 33 day
in end iel-transit Examiner		Sequentially list conditions	b. PANCRE		15 es e consequer	nce of):				30 days
an en iriei-tr		Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events			Γ	. 4				27 1
e attending physician end of or use es the buriel-transit is iclan/Medical Examir		Ceuse (Disease or Injury thet Initiated events resulting in deeth) Lest	c. Duade		es e consequen	ce of):				33 day
attendi I for use										
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should should									en eutopsy ormed?	24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?
page page								10	Yes 2 No	1 ☐ Yes 2 ☐ No
certificate hes rector, page 2		25. Wes case referred to medical					26. Place of De	eth (Check only o		72.100 22.10
		exeminer? 1 ☐ Yes 2 🗙 No	Hospital:	nt 2□E	R/Outpatient	3 DOA Ot	bor	Home 5□ Resi		or (Specify)
After fune		27. Manner of Deeth 1 Neturel 5 Pending 2 Accident investigation	28a. Dete of Injur (Month, Des	v 2	8b. Time of Injury	28c. Inju Wo		T	how injury occurre	
2 2 E 40		3 Suicide 6 Could not to determined	28e. Place of Injubuilding, etc	ury - At hom c. (Specify)	e, farm, street,	factory, office		28f. Location (City or To		er or Rural Route Number,
s effer death. In Director: Affer to ed in by the funera Certification:			hysician: To the best of	of my knowl	edge, death oc	curred et the ti	ime, dete end plec opinion, deeth occ	e, end due to the urred et the time,	ceuse(s) and mer	nner es steted.
24 hours effer de Funeral Directo letely filled in by the dical Certific		29a. Certifier 1X Certifying Pl (Check only one) 2 Madical Exa	mfner: On the basis of	ted.		gation, at my				nd due to the ceuse(s)
vithin 24 hours effer de o the Funeral Directo completely filled in by th Medical Certific		(Check only 2 Madical Exa	mfner: On the basis of end menner sta	ted.		29c. Licens				nd due to the ceuse(s) (Month, Dey, Year)
n 24 hou ne Funer pletely fill edical		(Check only 2 Madical Example one) 29b. Signature end title of certifier	miner: On the basis of end menner sta	ted.	10	29c. Licens			29d. Dete signed	nd due to the ceuse(s)
within 24 hours effer de To the Funeral Directo completely filled in by the Medical Certific		(Check only 2 Madical Example)	miner: On the basis of end menner sta	ted.	(Type, Prin	29c. Licens	se number)	29d. Dete signed	(Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** Mary Lillian Hubbard February 13, 1998 11:45 am /Medical 4e. Feclity Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Greenbelt Nursing Home Greenbelt Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) Deys Hours 1 □ M 2 🖾 F Yrs. 577-36-7388 70 1927 Washington, DC Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 No Yes 2 No Director Maryland Prince George's Greenbelt 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7010 Greenbelt Road 20770 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: Specify: White by 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Frank E. Steele Mary Ann Pettit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Douglas B. Hubbard - Son 270 Longwood Drive, Stafford, Virginia 22554 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 02/14/98 Alexandria, Virginia 21. Signature of Funerel Service Licenses 22. Name end Address of Fecility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) weekl DREU MONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cerebral ANTENIOSCUERCEIS by Completed 24e. Was en eutopsy performed? Were sutopsy findings evallable prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: Other: 4₺ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 MNatural 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted. 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mainter as steled. 29b. Signeture end litle of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D05891 February 14, 1998 20 gm 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) 6510 Kenilworth Avenue #2400, Riverdale, MD 20737 Roger B. Ingham, M.D.

State

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wed cal Examiner insist to notified at

permit. Peges 1 and 2 should be filed within 72 hours efter of Dependment of Health end Mental Hygiena. Important: If Item 27 Is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examines

Physician /Medical

Examine

attending physicien and I for use es the burial-trensit

signed t

page 2 s

certificata

To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this certifica completely filled in by the funaral director, t

thet the death certificate be axecuted

P.O. Box 68760,

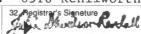
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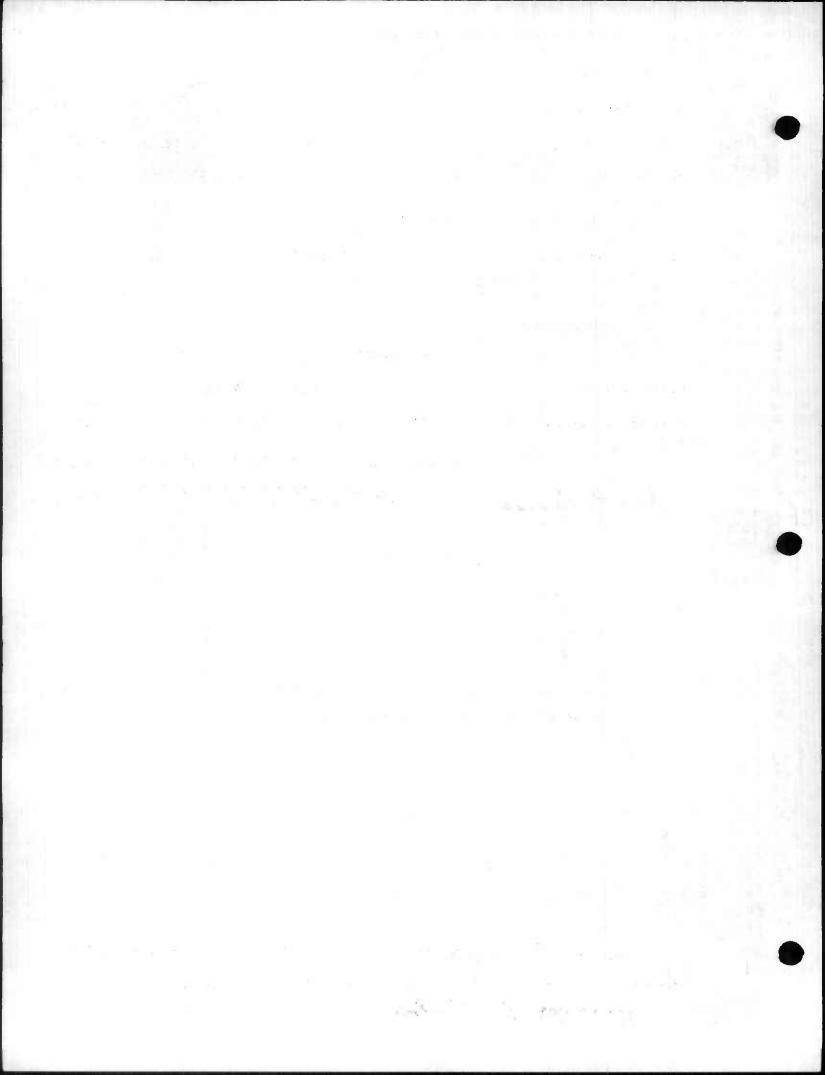
Baltimore, Maryland 21215-0020

the Meryland

31. Date filed (Month, Day, Year) FEB 17 1998



Registrar



State of Maryland / Department of Health and Mental Hygiene 9 8 0 7 0 2 1

						Cert	ificate of	Death	,	Reg. No.	0700	
			1. Decedent's Neme (First, Middle, La	ist)					2. Dete of De Month	eeth	3. Time	of Death
	Physici /Medi		Ryland Alton H	ale					Februa	ry 15, 1) pm
)	Examir		4e. Fecility Neme (If not institution, gi	re street end number)				4b. City, Town, o	r Location of Deet			
			1308 Nicholson	Street				Hyatts	ville	Prin	ce George	e's
2	Funeral Director			Sex 7. Age ((In yrs. lest birt 86		Months Deys		n. (Month, De	oy, Year) 28, 1911	9. Birthplece (Stet Country) Virginia	e o <i>r Foreign</i> ł
	and w		10a. State 10b. County	11	10c. City, Towr	n or Loca	ation				10d. Inside	City Limits
	Many f sh	ō	Maryland Prince	Caamaala	77		11					es 2 No
	28s	rec	10e. Street end Number	George s	Hyatt	LSV1	10f. Zip Code			10g. Citizen of W	het Country?	
	3a o	Funeral Director	1308 Nicholson	Street			2078	2.2		U.S.A	2011	
	death mms 2	Jera	11. Meritei Status	12. Was Decedent Ev	er in U,S.	13. Wa			(Specify Yes or No orto Rican, etc.)		- American Indien,	
21215-0020	be filed within 72 hours aftar death with the Maryland nat Hygiene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 💢 Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:			res, specify Cub ☐ Yes 2 🔯 No		erto Rican, etc.)	Specify:	White, etc.	
5-0	72 hc	Completed	15. Decedent's E (Specify only highest gr	ducation	16a.	Deceder	nt's Usuel Occup	pation during most of w	orkina	16b. Kind of Bu	siness/Industry	
121	within ana. than	nple	Elementery/Secondary (0-12)	College (1-4or 5+)		life. DC	NOT use retire	d)	UNRING			
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Mai	12 st h and r is n		19e. Informent's Neme/Relationship			_			Ru <i>ral Rou</i> te Numb			
	Health and 27 learn 2		Margaret C. Hale 20a. Method of Disposition	- Wife			Nicholson (Name of	on Stree	t, Hyatt		Maryland	
סר	A lite		1 Burlel 2 ☐ Cremation 3 ☐		cemeter	y, creme	tory or other ple	•			City or Town, Stete	
Baltimore,	rtme rtant		4 Donetion 5 Other (Speci		Fort I		oln Ceme		2/19/98	Brentwo	ood, Mary	land
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or other treumstic espace.		21. Signeture of Funeral Service Lica	1500		Fra	Neme end Addre ancis Ga 39 Balti	sch's S	ons Funer enue, Hya	ral Home	P.A.	781
П			23a. Pert1. Enter the diseese, or com- shock, or heart failure. List only	plications that caused the	ne death. Do n	not enter	the mode of dyi	ng, such es cardi	ac or respiretory e	rrest,	Approxim	nete
	Physician			-							Onset en	nd Death
	/Medicai Examiner	-	Immediate Ceuse (Final disease or condition	SMAL	· L Ca	266	- Lu	ING 1	CANCE	ER	7 N	onths
	Examinio	_	resulting In death)	Du	ue to (or es e c	conseque	ence of):					
	be sit	ine		b. —————							l	
	and Fran	Examiner	Sequentially list conditions, if env. leading to immediate	Du	ue to (or es e c	onseque	enca of):					
68760,	death cartificata be axecuted e attanding physician and od for usa as tha bural-transit	a E	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	C								
587	phys phys s tha	Aedical	thet initieted events resulting in deeth) Lest	Du	e to (or es e c	onseque	ince of):				į	
	cartific ding p	3		d								
Вох	that the daath car ed by the attandir detached for usa	Physician/									1	
P.O.		ysi	Pert II. Other significent conditions of	ontributing to death but i	not resulting In	the und	erlying cause gi	ven in Pert I.			tribute to the caus	
0	res that signed b								_ 1⊔	Yes 2⊔ No	3Probably 4	Unknown
of Vital Records,	requires that the	d by							24e. Wes	en eutopsy	24b. Were autops	y findings
S	- and (0)	iete							perfe	ormed?	aveileble pric	ir to if cause
Re	The law ate has t paga 2 s	Completed									of death?	
G	n: Th ficate or, pa	CO	25. Wes case referred to medical							Yes 2 No	1 ☐ Yes 2	∐ No
5	Physician: this certific	00	exeminer?	Hospitel:			Oti	nor:	eeth (Check only			
o	Phys rthis arel d	To To	27. Menner of Deeth	1 ☐ Inpatient 28e. Dete of Injury			3LI DON	4 Li Nursing	Home 5 🖾 Resi	how injury occurre		
Division	Attending Physician: The is and death. ector: After this certificate haby the funeral director, page by the funeral director, page.	tior	1 ■Neturel 5 Pending 2 Accident Investigation	28e. Dete of Injury (Month, Dey Y	(ear) In	njury	28c. Inju Wo M 1 □	rk? Yes 2 □ No				
S	or Attendi after death. Director: A In by tha fe	fica	3 Suicide 6 Could not b	e One Plant of lainer	- At home, far	rm. stree			28f. Location (Street end Numbe	r or Rural Route N	umber.
á	25-5	Certification:	4 Homicide	bullding, efc. ((Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To			
	spita hours neral y fille		29a, Certifier 1 Certifying Pt	ysician: To the best of r	ny knowledge.	, deeth o	ccurred et the ti	me, dete end pled	ce, end due to the	cause(s) end mer	ner es steted.	
	To the Hospital or within 24 hours after To the Funeral Director Complataly filled in	edicai	(Check only 2 Medical Examone)	niner: On the basis of ex end menner stete	xemination end	d/or inves	stigation, in my o	opinion, deeth occ	curred et the time,	date end place, e	nd due to the cause	∋(s)
	To the Complex	X	29b. Signeture and title of certifier	P			29c. Licens			29d. Date signed	(Month, Day, Year,)
			1 Quyor	Xom Q			1) 4	+1119		Feb 1	6, 19	98
	(12)		30. Name and eddress of person who DAYA SHARM	completed cause of deel	th (Item 23e) (Typa, Pri	int) VSTON	OR. #3	203 Rec	kvillo	ind 20	852
	Sta	te	31. Dete filed (Month, Day, Year)	32 Registrar's				,,,,				
	Registr	ar	FEB 1 7 199	8 Salis	indear to	Mall						

94. TI 93.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

							Certificate of	of Death		Reg. No:	U/	022
	D		1. Decedent's Nar	me (First, Middla, La	st)				2. Date of Dec		Year	3. Time of Death
	Physici /Medi		The	resa	Hoff	man			FEBRUS			2:00 PM
	Examir		Calculate Property and Calculate Control of the Calculate Control of th	(If not Institution, giv				4b. City, Town, or	Location of Death	4c. County	of Death	
1			Prince	George's	Hospital	Center		Chever1v		Prince	e Ce	orge's
Г	Funeral		5. Social Security	Number 6. S	Sex 7. A	ge (In yrs. last b	irthday) If Under 1 Ye Months Day			h	9. Birthpl	ace (Stata or Foreign
	Director		577-66-62 Usual Residence	212	I M 2 TF	58	Yrs.	, , , , , , , , , , , , , , , , , , , ,	Jan. 21			ington, D.
	how		10a. State	10b. County		10c. City, To	wn or Location				10	d. inside City Limits
	tha Ma 28a-1 s outflex	Director	Maryland	Prince G	eorge's	Co1ma	ar Manor			40- 022	***	1 ☐ Yes 2 🛣 No
	Aith O S						10f. Zip Code	В		10g. Citizan of \	wnat Count	iry7
	ath v	ra		roe Stree			20722			United :		
	ar de	Funeral	11. Maritai Status		12. Was Deceden Armed Forces	7	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (uban, Mexican, Pue	to Rican, etc.)	Blace	ce - America ck, White, e	
020	72 hours after death with the Maryland naturel', or items 23s or 28s-f show Jicel Examinet must be notified at	by		rried 2 Married 4 Divorced	1 Tes 2 Hes 1 Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 N	No Specify:		Specify	Whi	te
21215-0020	n 72 hours "naturel",	Completed	(Spe	15. Decedent's Ed	ducetion ada completad)	16	a. Decedent's Usuai Occ (Giva kind of work dor lifa. DO NOT usa rat	cupation ne during most of wo	orking	16b. Kind of B	usiness/Ind	ustry
12		du	Elementery/Sec	ondary (0-12)	Cotlege (1-4or	5+)	iifa. DO NOT usa rat	rred)				
			17 Father's Name	(First, Middla, Last)		Wa	itress	10 Matheria Na	ma /Finat Mindella	Food Se		2
ano	Mental Is Merked of arked of	Be		(I iist, iviiddia, Last)				16. Mother's Na	me (First, Middle,	Maidan Sumen	na)	
Maryland	d 2 should be filed th and Mental Hygi 7 is marked other treumatic event,	70		rnard Sim					ed Viola			
Ma	2 6 50 5		19a. Informant's N	Name/Relationship (Type, Print)	19	b. Meiling Address (Stre	eet end Number or R	lu <i>ral Rou</i> ta Numbe	er, City or Town,	Stata, Zip	Coda)
	laaliaalia Per		James Ro	ger Hoffma	an-Son		3618 Melfa of Disposition (Nama of	Lane, Bow	ie, Mary	TOTAL	0715_	
0	gas if ita		20a. Method of Dis	sposition ☑ □ Cremation 3 □	Removal from State		ary, crematory or othar p	olaca)	Date	20c. Location -	City or For	en, State
altimore,	man ant:		4 Donation	5 ☐ Other (Specify	y)	Fort I	incoln Cem	eterv	2-20-98	Brentwo	od. M	arvland
Bal	permit. Pagas ' Department of Important: If its any injury or ot		21. Signature of F	uneral Service Dipen	901.		22. Name and Add	dress of Facility				,
ш	20599		10	USA (S.)	runcoo	N	Fort Linco	oin runera	al Home L. Brent	wood. M	arv1a	nd 20722
			23a. Part1. Enter	the disease, or con	plications that cause	d the death. Do	not enter the mode of o	dying, such as cerdia	c or respiratory ar	rest,		Approximate Interval Between
a	Physician	178	Siroux, or free	art failule. List only	one cause on each	iiio.					1	Onset and Death
И	/Medicai		Immediate Cause diseese or conditi	(Final	Λ.	1 . R		. E.	1		-	2 wesks
П	Examiner		resulting in death))	a. /-\Cu	Due to (or es	espirator	y rai	ine			2 DU ESTO
_	D =	ner			A	0	e consequence of): enal F consequence of): ulmonar consequence of):	= 1.0			- 1	21
	cata be axecuted physician and s tha bunal-transit	Examiner	Sequentially list of	onditions.	b	Due to (or as a	consequence of):	ac i inc	Name -		1	K meet
ó	a axe an a unal-l		Sequentially list of if any, leading to it cause. Enter Und Cause (Disease o	mmediate lerlying	Pain	- 0 1 0	100000	14.00-7	tour		i	10 years
68760,	nta bu	Ica	that initiated event resulting in death)	15	C	Due to (or as a	consequence of):	11770	and lon		1	/ - 4
	E 0 0	Medical	resulting in death)	Last	0.01		a cerations	-11	1/0-10-0	1	1	Sweek.
Box	aath car attandir I for usa				d. Gast	Perfo	a ceraciona	- well	pergu	rige		SWEEN
	daat a att ed fo	Physician/	Part II. Other sign	ficant conditions o			in the underlying ceuse	given in Part i.	23b. Did t	obacco use co	ntribute to	the cause of death?
P.0	that tha da ned by tha a datached t	h							10	Yas 20 No	3 Prob	ably 4 Unknown
	S 50 0	by										
pro	v require bean si should	ba								an autopsy rmed?	24b. We	re autopsy findings illable prior to
000	> 10 00	plet							pono		con	npletion of cause leath?
ĕ	a - 6	Completed							101	es al No	1	Yes 2□ No
ta	ifcian: Th cartificata rector, pa	Bec	25. Was case refe	rred to medical	8			26 Place of De	eath (Check only o			
of Vital Records,	Physician: this cartific	To B	examiner? 1 ☐ Yes 2 🔀		Hospital:	ient 2□ER/C	Outpatient 3 DOA	Other	Home 5 Resid		er (Snecih	1
	Phy arthi		27. Manner of Dee		28a. Date of fnj	ury 28b.	Time of 28c. In		28d. Describe h			/
ion	nding f th. : Aftar a funar	atio	1 Naturai 2 Accident	5 Pending investigation	(Month, D	ay raar)		Vork7 ☐ Yes 2 ☐ No				
Division	for Attending after death. Director: After din by the fune	Certification:	3 Suicide	6 Could not be determined	28e. Place of Ir	jury - At home, f	arm, street, fectory, offic	Се	28f. Location (S		ber or Rural	Routa Number,
ā	afta Dire	ert	4 Homicide		building, e	tc. (Spacify)	•		City or Tow	m, Stata)		
	Hospital 24 hours Funeral staly filled		29a. Certifier	15 Cartifying Ph	ysician: To the best	of my knowledg	e, death occurred at the	time, date and plac	e, and due to the	cause(s) and me	enner es ste	eted.
	To the Hospital or At within 24 hours after of To the Funeral Direct completaly filled in by	edical	(Check only one)	2☐ Medical Exam	nfnar: On the basis of and manner s	of examination a	nd/or investigation, in m	y opinion, death occ	urred at the time,	date and place,	and due to	the cause(s)
	To the within 2 To the comple	×	29b. Signature and	title of certifier			29c. Lice	ense number		29d. Date signe	d (Month, L	Day, Yaar)
			D N/	. <	to lo	3 —	D.	2015		7-17-	96	
	151		30. Name and add	lress of person who	completed cause of	death (Item 23a)	(Type, Print)	13		4-1/-	11	0 20785
)		Louis		inberg	MO	(462	Landa	RII		, M	0 20755
	Sta	te	31. Date filed (Mor		32 Regist	rar's Signature	6776	- 0 0.00	100 6	-cina ove	n. / . l.	J 20/45
	Registr		FE	B 1 9 1998	Selli	rar's Signature	roball,					

DHMH 16 Rev 6/95

February 15, 1978 - 2100 FM

-43 000 - 10 -00 0

3. TIME OF DEATH

10d. INSIDE CITY LIMITS?

14. RACE — American Indian, Black, White, etc.

1 X YES 2 NO

3 Wells

8. BIRTHPLACE (State or Foreign

9c. COUNTY OF DEATH

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

USA

Connor

4:55 A

i	1. DECEDEN
	4. SOCIAL S 124-
	9a. FACILITY
	RESIDEN
N	10a. STATE

1

DIRECTOR

FUNERAL

BY

COMPLETED

2

19a. INFORMANT'S NAME (Type/Print)

cause. Enter UNDERLYING CAUSE (Disesse or Injury

that initiated events resulting in death) LAST

27. MANNER OF DEATH

1 Natural

2 Accident

3 Sulcide

4 Homicide

Julia H. Conti

once.

70 notified

pe

must

examiner

medical

the

event,

traumatic

other

6

Injury,

any

CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

BE

2

use as the burial-transit permit. Pages 1, 2, 3 should

retained by the hospital or attending physician.

Page 6 may be

death.

executed

O. BOX

for

page 5 should be detached

funeral director,

filled in by the fi hours after

n and completely fill to burial, cremation,

the attending physician Mental Hygiene prior to the death certificate be

n signed by the Health and A

t. of Healt shows a requires

has be Dept.

with t marked,

DIRECTOR: After the hours after death water 158 is mark

FUNERAL within 72 h HOSPITAL

THE Day

Item the State

9

BALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO

FOR STATE REGISTRAR CERTIFICATE OF DEATH NT'S NAME (First, Middle, Last) 2. DATE OF DEATH Hill arylee Connor February 16, 1998 SECURITY NUMBER 5. SEX 7. DATE OF BIRTH 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. April 2,1917Baltimore, Md 18-7743 DAYS HOURS MIN 1 M 2 X F 81 YRS. Y NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH Hills Nursing Home Wheaton 10b, COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Wheaton 10e. STREET AND NUMBER 10f. ZIP CODE 4011 Randolph Road 20902 11. MARITAL STATUS WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES If yes, specify Cuban, Maxican, Puerto Rican, etc.)
t VES 2 NO Specify: 1 Never Married 2 Married

Speedly Other 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Graphic Artist Government 18. MOTHER'S NAME (First, Middle, Maiden Surname)

17. FATHER'S NAME (First, Middle, Last) F. Hill Leroy Julia

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Rown, State, Zép Code) 20910, 8750 Georgia Ave.,#11113B(Silver Spring, Md.

20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Northern Va. Crematory 2/17 Arlington, Va. 21. SIGNATURE OF FUNERAL SERVICENCENSEE 22. NAME AND ADDRESS OF FACILITY ral Service, Inc.

4001 Benning Rd., N.E. (Wash., D.C. 2001 Enter the diseases, or complices ahock, or heert fellure. List only 23. PART I. Enter the diseases, ons thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate

one cause on each line IMMEDIATE CAUSE (Final disesse or condition neumonia reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) Sequentielly list conditions. If sny, lesding to immediate

DUE TO (OR AS A CONSEQUENCE OF) DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to deeth but not recuiting in the underlying cause given in Pert I.

24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 TYES 2 NO OF DEATH? 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🗵 UNCERTAIN 🗆 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL 1 TES 2 NO

OTHER:
Nursing Home 5 - Residence & Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED

5 Pending Investigation м 1 YES 2 NO 28a. PLACE OF INJURY — At home, tarm, street, factory, offica building, atc. (Specify) a Could not be

28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29s. CERTIFIER (Check only (Ch

2 MEDICAL EXAM nination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

AND ADDRESS OF AUSE OF DEATH (ITEM 27) (Type, Prir

039032 FARRAGUT AVE 3720

2/16

DIVISION OF VITAL RECORDS, P. OR ATTENDING PHYSICIAN: The law

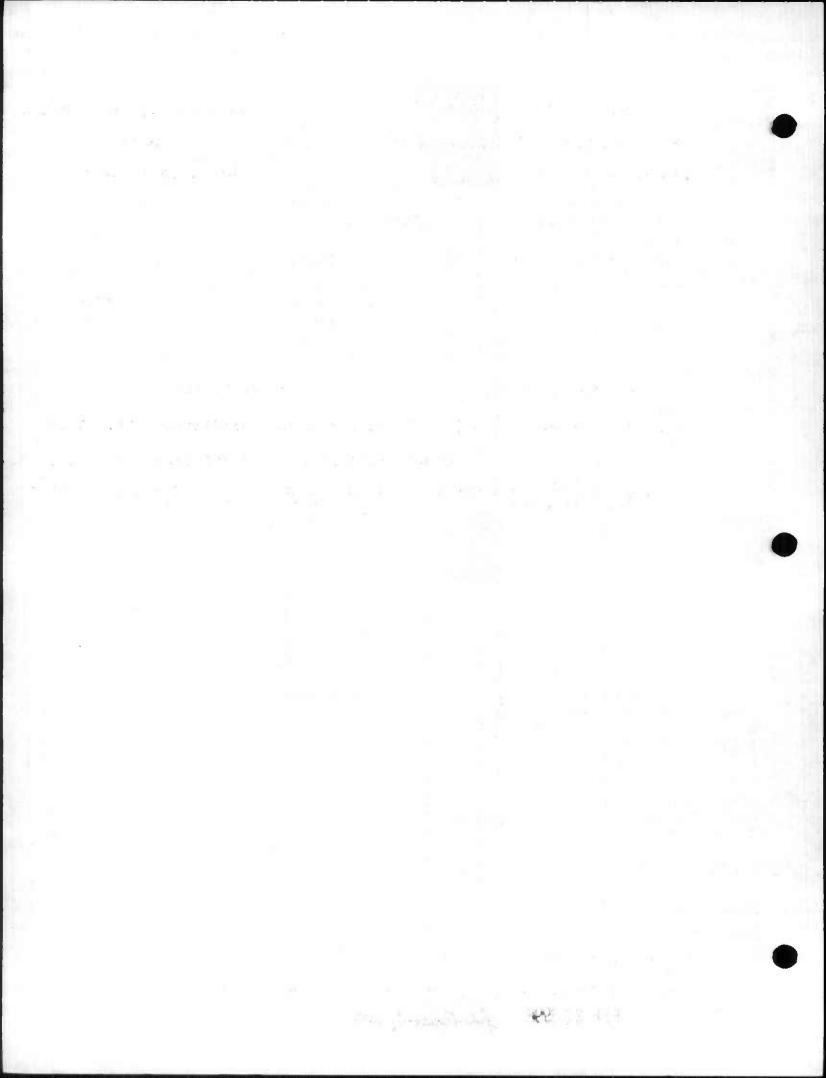
MPORTANT: If 2 2 3

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State of Maryland / Department of Health and Mental Hygiene

			4			C	ertificate of	Death		Reg. No.	0/02	4					
	Dharata	,	1. Decedent's Neme (First, Middl	e, Last)		-			2. Data of De Month	eath Day	3, Tin	ma of Death					
	Physic /Medi		HAROLD	HALEY					Februa			0:00pm					
	Exami		4a. Facility Neme (If not institution	n, give street end num	ber)			4b. City, Town, or				0.000					
			Medpoint Con	tinuing	Care	Faci	lity	Elkton	1	Cec	il						
	Funeral		5. Social Sacurity Number	6. Sax 7	. Age (In yrs.		y) If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th	9. Birthplace (St Country)	ate or Foreign					
	Director		218-18-1495	1 <u>⊠</u> M 2□F		86 Yrs.	Months Days	Hours Min.		1 1911	Maryla	nd					
	p.		Usual Rasidance of Dacedent														
	show		10a. Stete 10b. County		10c. Ci	ly, Town or						de City Limits					
	r 28a-f sh	9	MD. Ce	cil		Ear	leville				10	Yes 2∏No					
	F 4	le le	10e. Street and Number				10f. Zip Coda			10g. Citizan of V	Whet Country?						
	15 w	Funeral Director	20 Kent Rd.	Crystal	Beac	h	2	1919		U.S.	. A .						
	lar des	ine!	11. Marital Status	12. Wes Deced	lant Evar in U	l,S. 13	I. Was Decedant of I	lispanic Origin? (S	Specify Yas or No	- 14. Rac	e - American India	ın,					
Maryland 21215-0020	72 hours after death with the Maryland natural', or flerne 23a or 28a-f show dical Examiner must be notified at	b	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	ied 1 Yes 2	No.		1 ☐ Yas 2 🙀 No		io riioon, ato.,	Specify		9					
2-0	72 ho	Completed	15. Decedan (Specify only higha	t's Education		16a. Dec	edeni's Usual Occup ra kind of work dona DO NOT usa ratire	pation	dela a	16b. Kind of B	usiness/Industry						
21	c • 5	pje	Elemantary/Secondary (0-12)	Collega (1-	4or 5+)	lifa.	DO NOT usa ratire	during most or wo	rking								
2	od with giana. er than	5	8				Painter			Boat	Yard						
Pu	al Hygia Cother i	36	17. Fether's Neme (First, Middle,	Last)				18. Mothar's Na	ma (First, Middla	, Maiden Surnam	10)						
la	s 1 and 2 should be filed with! f Haalth and Mental Hygiana. tem 27 Is marked other than other traumatic event, the M	To Be	George Samı	uel Haley	r			Mary 1	R. Ever	cett							
a	s ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Ma	liing Addrass (Street	and Number or R	ural Route Numb	er, City or Town,	Stata, Zip Code)						
	and salth		Harold J. Hai	ley (s	on)	413	N. Broa	ad St.	Middle	etown,	DE. 197	709					
ore	item of Ha		20a. Mathod of Disposition			Place of Dis	position (Nama of ematory or othar pla	ce)	Deta	20c. Location -	City or Town, Ster	te					
Ĕ	Page mt: #		1 ☐ Burial 2 ☐ Crametion 4 ☐ Donation 5 ☐ Othar (S				Cemetery		/24/98	Chesap	eake Ci	ity MD					
Baltimore,	permit. Pagas 1 and 2 Department of Haelth a Important: If Item 27 is any Injury or other tra once.		21. Signature of Funaral Service	Licensee			22. Name and Addre	ess of Fecility									
m	Depa Impo		1 Hood	Bethel Cemetery 2/24/98 Chesapeake City MD Signature of Funaral Service Licensee M00510 Bethel Cemetery 2/24/98 Chesapeake City MD 22. Name and Address of Fecility Galena Funeral Home of Stephen L. Schaec Box 235 Galena, MD. 21635													
0			23a. Part Enter the disease, or shock, or learn failura. List	complications that car	used tha daal	h. Do not e	OX 235 ntar tha moda of dvi	Galena	MD. 2	21635 rrest.	Approx	rimate					
	Physician		shock, or lifearl failura. List	only ona causa on aa	ch lina.		,				tntarva	l Batween end Deeth					
	/Medicai		Immediata Cause (Finel	<i>a</i>)	,		1 1	,									
	Examiner	ш	diseasa or condition rasulting in daath)	a. (7e			Arteria	schovosi	2		74	ronz					
		ē			Dua to (or as a cons	equence of):										
	Insit	뒽		b													
	death certificata be avecuted a attending physician and of for usa as the burtal-transit	Physician/Medical Examiner	Sequentially list conditions, if eny, laading to immediata ceuse. Entar Undarlying Causa (Disaase or Injury		Dua to (or as a cons	equance of):				1						
68760,	sola sola	la l	Causa (Disaase or Injury that initiated evants	c	0 1 1						-						
89	tificate ng phy as the	ğ	rasuiting in death) Last		Dua to (d	r as a cons	equance of):				İ						
Box	certi ding	3		d						_							
m	atter	ciai							1								
P.O.	v requires that tha death cel been signed by tha attendir should be detached for usa	ys	Part II. Other significant condition								ntribute to the car						
	that ded b	F.	Dishetes +	Ype Tr		500	ne cordi	10 my 0 Bo	thy 10	Yes 2∐ No	3 Probably	4 (Whiknown					
Division of Vital Records,	requires that tha een signed by the hould be detache	d by	Diohetes +	. ,				7	24a Was	an autopsy	24b. Ware auto	osy findings					
Ö	peen	Completed	Squomous	Cell Ca	of 5/2	·~ (~	real topla)		perio	ormed?	24b. Ware auto available p completion	rior to					
3e	has b	d L			/						of death?						
-	: The cata h		COPO						1 🗆	Yes 2 10	1 🗆 Yas	2□ No					
Vit	Attending Physician: The law ar death. •ctor: Attar this cartificata has by the funeral director, page 2	Be	25. Wes case rafarrad to medicel examinar?	Monitoli			011		ath (Check only	ona)							
of	hysl this c	은	1 Yas 2 No			· · · · · · · · · · · · · · · · · · ·	ent 3 DUA			dence 6 □Oth							
L C	Ing P	on	27. Mannar of Death 1 ☑Natural 5 ☐ Pandin		Dey Year)	28b. Tima Injury	Wo		28d. Dascribe	how Injury occur	ad						
Sic	eath or:	cati	2 ☐ Accident Investig	not be				Yas 2□No									
\leq	tracification by	Certification:	4 Homicida datarm	Ined 28a. Piace o	f Injury - At h , atc. (Specil	oma, farm, s	straat, factory, office		28f. Location (City or To	Streef and Numb wn, Stete)	per or Rural Routa	Number,					
	rai Dellied																
	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completaly filled in by the funer	edical	29a. Certifiar (Check only one)	g Physician: To tha be Examiner: On tha bas and manne	is of examina	wiedge, dea tion and/or	ith occurred at tha ti invastigation, in my o	ma, date and piace opinion, death occu	e, and due to the urred at tha tima,	cause(s) and ma data and place,	inner as stated. and dua to tha cei	usa(s)					
	To the To the Comp	×	29b. Signatura and titla of certifial				29c. Licans	sa number		29d. Data signe	d (Month, Day, Ye	ar)					
			112 0 0 0 0 0 0	Almaha.	in M	O	D-	07129		73 -	eb 98						
			30. Nama and addrass of person	who complated ceusa	50-	·		_ , , , , , ,		~ 3 [0 10						
			Wallace Ober		·	x 41		Lton, Mi	2101	3							
	Sta	te	31. Date filed (Month, Day, Year)	32. Rag	gistrar's Signa	itura											
	Registr	ar	FEB 23	1998	whia Daw	don-A	andelle										

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 5:307 Elaine B. Halvorsen /Medical 4a. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 207 Bayview Lane Unit 405 Ocean City Worcester If Undar 1 Year If Under 24 Hrs. 8. Hours Min. 5. Sociel Security Number Dete of Birth (Month, Day, Year 10/22/22 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys 1 M 2 X F Yrs Director 080-22-3694 75 NY Usuel Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Menyland Department of Health and Mentel Hyglene. Important: If Item 27 is marked other than "natural", or frems 23a or 28a-f show any injury or other traumatic event, or Medical Examinat revent be notified at 10a. State 10h County 10c. City, Town or Location 10d. fnsida City Limits MD Worcester Ocean City 1 XYas 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 Bayview Lane Unit 405 21842 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Bleck, White, etc. I ☐ Yes 2 💆 No f Yas, Give Yaar or Detes: 1 ☐ Nevar Married 2 XMarried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No by Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Nurse Health Care 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surnama) B Edith Reiner Milton Vodrhis ٥ 19a. fnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Robert Halvorsen/ Husband 207 Bayview Lane Unit 405 Ocean City, MD 21842 20a. Method of Disposition 20b. Plece of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burlai 2 ☐ Cramation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cape Henlopen Crematory 2/10/98 Frankford, DE 21. Signature of Fundaral Service Licenses 22. Neme and Address of Facility Burbage Funeral Home 108 william St. Berlin, MD in, or a implications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Pancrealic LANCES Examiner Dua to (or es a consequence of) Examiner The law requires that the death certificate be executed Sequantielly list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or Injury that initiated evants rasulting in death) Lest pue Due to (or es a consequence of): attending physiclan elfor use es the buriel-Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): signed by the at id be deteched for Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to completion of causa of deeth? Completed 24a. Wes an autopsy performed? r this certificete hes 1 Yes 2 No 1 Yes No Hospital or Attending Physician: ' 24 hours efter death. Funeral Director: After this certifice 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetlent 3 ☐ DOA 1 Yes ≥ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Daath 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? Neturel 5 Pending investigetion 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Atterwithin 24 hours efter de To the Funeral Directo completely filled in by the 3 Suicida 6 Could not be 28e. Place of Injury - At homa, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 4 Homicide edical 29e. Certifian Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner steted.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature end title of certifier

197

FEB 1 2 1998

- ND 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

HOTHIND WD 32. Registrer's Signeture

10445 O.C. BIVD Bell MD 21811 relia Davidson-Bandalle

29c. Licensa number

20051232

29d. Dete signed (Month, Day, Year)

994

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 8 07026

					Cert	ificate of	Death		Reg. No.	0 1	020
	Dhysia		Decedant's Nama (First, Middla, Last)					2. Data of De	eath Day	Year	3. Tima of Death
	Physici /Medi		Edmund Francis Jones					Februa			8:20 p.m.
	Examir		4a. Facility Nama (If not institution, give street and number)				4b. City, Town,	or Location of Deel	h 4c. County	ot Deeth	
			Prince George's Hospital				Chever		Prin	ce Geo	rge's
	Funeral		1MM 2DE	In yrs. last bir	thday) Yrs.	If Undar 1 Yaa Months Days		lin. (Month, D	ay, Year)	9. Birthpla Country	aca (Stata or Foreign
	Director		578-24-9498 Usual Rasidence of Decedent	72	115.			Oct. 7	, 1925	Washi	ngton, DC
	land mow			Oc. City, Tow	n or Loca	ation				100	d. Insida City Limits
	Mery	ō	Maryland Prince George's	Hyat	tevi	110					1 Yas 2□No
	1 28a	rec	10e. Street and Number	nyat	CSVI	10f. Zip Coda			10g. Citizan of	What Countr	ry?
	3a o	0	4814 71st Avenue			2078	4		U.S.A		
	d 2 should be filed within 72 hours after death with the Meryland th end Mental Hygiena. 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinat must be notified at	Funeral Director	11. Maritel Stetus 12. Was Decedant Eve	ar in U,S.	13. W	as Decedent of	Hispenic Orlgin?	(Specify Yes or No larto Rican, atc.)	- 14. Rac	ca - Amarica	
0	after or he	Fu	1 Nevar Married 2 Married 1 Nevar Married 2 No If Yes, Giva					iano Hican, atc.)		ck, White, at	ic.
00	ral!.	l by	3 ☐ Widowed 4 ☐ Divorced Yaar or Datas:	WWII	"	□Yas 2⊠ No	Specify:		Specif	w: Wh	ite
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7	filed within Hygiena. other than ent, the Men		11	P	1umb	er	T		Plumb		
anc	be fi	Be	17. Fether's Nema (First, Middle, Last)				18. Mothar's I	Nama (First, Middle	, Maidan Sumar	na)	
Z	12 should be fi end Mental Iv is marked out	70	Edmund Virgil Jones 19a. Intermant's Name/Ralationship (Type. Print)					Bauer			
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e,	s 1 and 2 of Health e item 27 is		Margaret M. Jones - Wife 20a. Method of Disposition	20b. Place of	Disposi	tion (Name of		attsville Data	20c. Location	0784 City or Tow	m. Stata
no	ages ont of t: If if		1 Departure 5 Other (Secrital)			atory or other pl	•				
Baltimore,	ortan Solur		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licansee	rort.	7	oln Cem		2/12/98	Brentw	ood, N	laryland
Ba	permit. Pages 1 and Depertment of Health Important: if item 27 any injury or other tr 2002.		Class Octor 1 as	0	Fr	ancis G	asch's	Sons Fune	ral Home	e, P.A	٨.
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	Physician		23a. Pert1. Entar tha disaasa, or complications that caused th shock, or haart failura. List only ona causa on each line.	a dada. Do	iot oritar	tha moda or dy	ing, such as care	ade or raspiratory a	masi,	1 1	Intarvel Between Onsat and Death
у.	/Medical		Immediata Ceusa (Finel							1	
	Examiner		rasulting in daath)	-		157,50	ASCULAR	DISEASE			
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oʻ	a axe		Saquentielly list conditions, if any, leading to immadiata causa. Enter Underlying Ceuse (Disaase or Injury c.								
68760,	ate b hysic the bi	Medical		e to (or as a c	consaqua	anca ot):				1	
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Вох	eath ce attandii I for use	Physician/	<u> </u>								
o.	by the a	ysic	Part II. Other eignificant conditione contributing to death but r	not rasulting in	tha und	tarlying causa g	ivan In Part I.	23b. Did	tobacco usa co	ntribute to t	the cause of death?
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Record	v requires been sign should be	Completed							an autopsy ormad?	avail	e eutopsy findings labla prior to plation of causa
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	ding h. After fune	lo l	1 Naturel 5 Panding (Month, Day Y	aer) 280.	rima of njury	28c. Inju Wo	ork?]Yes 2∐No	280. Dascribe	how injury occur	Ted	
Division	Attending it death.	lical	2 Accident Invastigation 3 Suicida 6 Could not be datermined 28a. Placa of Injury	- At home to	rm etrac			28f Location	Street and Numi	her or Bural I	Boute Number
Ο̈́	or Atten aftar deal Director:	Certification:	4 Homicide datermined 20a. Place of Injury building, atc. (Specify)	iii, stroc	st, ractory, onica	•	City or To		on marari	Todia Wallioor,
	Hospital 24 hours Funeral etely filled		29e. Cartifiar 1 Certifying Physician: To the best of m	ny knowledge	, deeth o	occurred at the t	ime, dete end pla	ace, and dua to tha	cause(s) and m	ennar es stel	ted.
	Ho Ho	edicai	(Check only one) 2 Medical Examiner: On the basis of examiner states	amination an	d/or Inva	stigation, in my	opinion, daath o	ccurred at the tima,	date and plece,	and dua to the	ha cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	M	29b. Signature and title of certifier	17.		29c. Lican	sa number		29d. Data signe	d (Month, De	ay, Yaar)
			CHULL STRUE	1//	Dim	D3	3954		Februar	v 12	1998
	(m) 111		30. Nama and addrass of person who completed cause of dust	h (1em 23a)	_		- J J T		LULUAI	. , 14,	1770
	IV/ IV	al		/			ve, Chev	erly, MD	20785		
	Sta	te	31. Dete tiled (Month, Day, Year) 32 Registrar's	Signatura	1 11						
	Registr	ar	CED 17 1998 9:44.00	THE PERSON	TOPE,						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of the Month **Physician** February 1998 1:20 pm Ella H. Johnson /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Wicomico Wicomico Nursing Home Salisbury If Under 1 Year | If Under 24 Hrs. | Months Deys Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 217-05-3873 Yrs. 96 2/18/01 Md. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Wicomico Salisbury 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4596 Nutter's Crossroad 21804 U.S.A. Funeral 12. Wes Decedent Ever in U,S. 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: white þ 3 Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) seamstress sewing factory 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) George Hill Katherine Trader Hill 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Emerson Burbage 4596 Nutter's Crossroad, Salisbury, Md/21804 20b. Plece of Disposition (Neme of cemetery, cremetory or other pieca) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) Springhill Cemetery 2/9/98 Girdletree, Md. 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility P.O. Box 87 seluni Dennis Funeral Home, Snow Hill, Md. 21863 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Ongestive Hearth Failure

Due to (or es e consequenca of):

Oronary Antrey Disease

Due to (or es e consequence of): Immediate Cause (Finel disease or condition resulting in death) Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24e. Wes an autopsy performed? Completed Osteo porosis Peytobe Feeder. 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) and menner es steled.

2 Medicat Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner steted. Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) unupoul D02026 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Federico G. Arthes, MD 1622A Ocean Pines Berlin, MD 21811 31. Dete filed (Month, Dey, Year)
FEB 1 3 32. Registrar's Signature
Auna Davidson Randalle

State Registrar

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-1 show other traumstic event, the Medical Examiner invaribe notified at

permit. Pages 1 and 2 should be filed within 72 hours after deeth w Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural" page.

Physician

/Medical

Examiner

the attending physician and hed for use es the burial-transit

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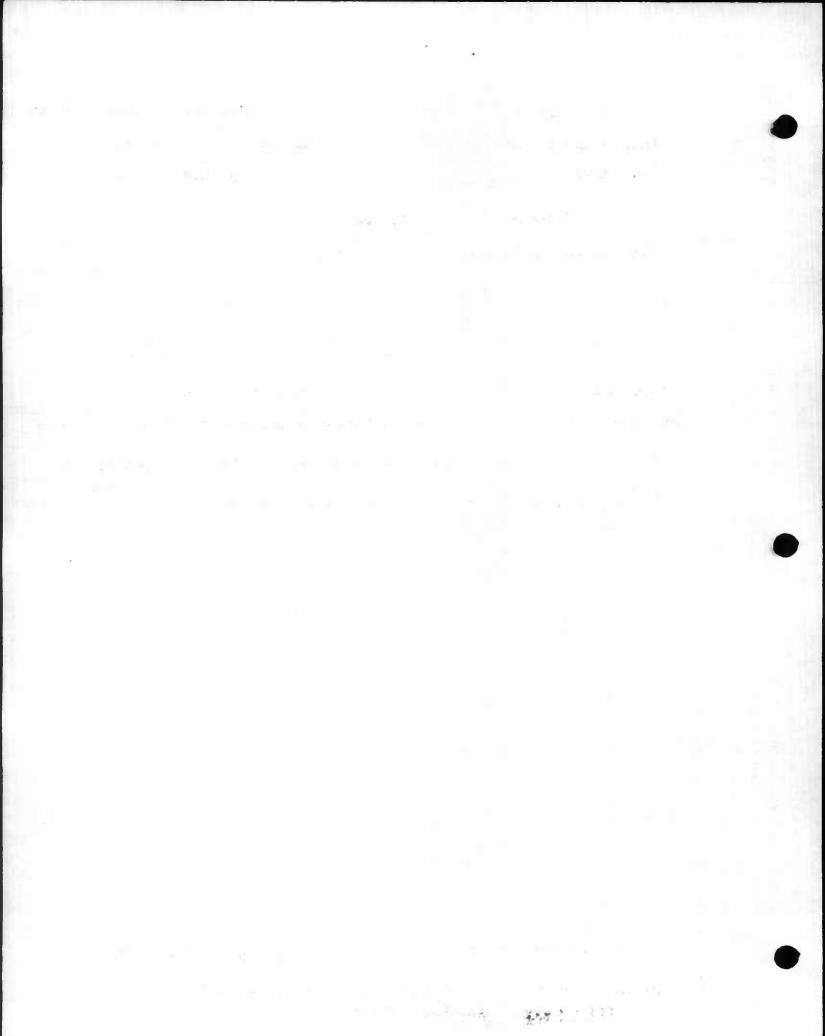
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funeral director,

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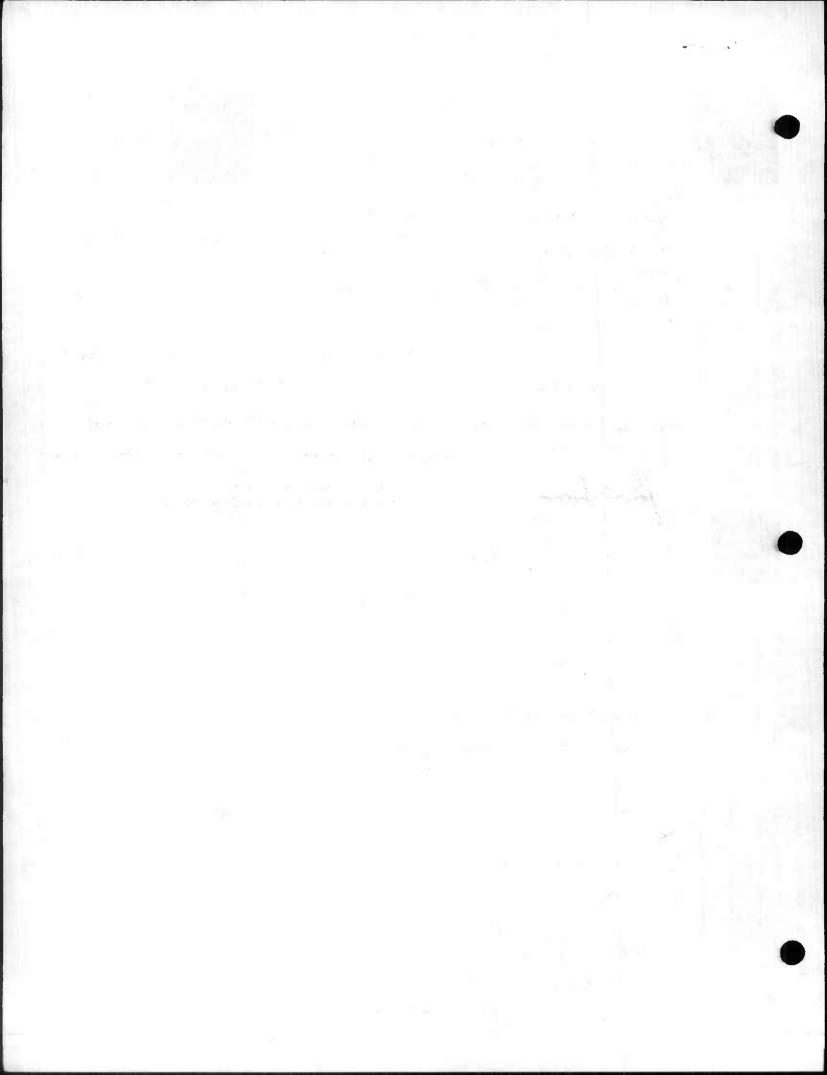
Division of Vital Records, P.O. Box 68760,

with the Maryland



State of Maryland / Department of Health and Mental Hygiene

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ŀ	Exami	ner	4e. Fecility Name (If not institution, g 304 W	ive street and number) illis St.			4b. City, Town, or L Cambridg		4c. County Dore	of Death Chester	
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	pur .		Usuel Residence of Decedent 10e. Stete 10b. County		10c City T	own or Location					nside City Limits
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	r 28a	rect	10e. Street end Number			10f. Zip Code		10	g. Citizen of V	Whet Country?	
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020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinat must be notified at 2008.	by Funeral Director	11. Maritel Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces? 1XYes 2 If Yes, Give Yeer or Detes:	Ever in U,S. No WW II	13. Was Decedent of If Yes, specify Cub		pecify Yes or No- Rican, etc.)		e - American in ck, White, etc. .: Whi	
21215-0020	d 2 should be filed within 72 ho h and Mental Hygiene. I is marked other than "natur traumatic event, the Mod cal	Completed	15. Decedent's (Specify only highest g	Education rede completed) College (1-4or t	5+)	6e. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire				usiness/Industry	190
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lan	fental fental ked o	To Be	Leroy Francis	King			Anni	e Doroth	y Nicho	ols	
Maryland	and No.		19e. Informent's Neme/Relationship	(Type, Print)		19b. Mailing Address (Stree	t end Number or Ru	ral Route Number,	City or Town,	Stete, Zip Code	e)
	Health am 27 i		Donna L. Johnson	n Daughter		1621 Stone B	oundary R				
lore	or off		20a. Method of Disposition 1 ☐ Burial 2XXCremetion 3	☐Removel from State	cem	e of Disposition (Neme of elery, cremetory or other ple	oce)			City or Town, S	
Baltimore,	it. Pa rtmer rtant: njury		4 ☐ Donation 5 ☐ Other (Special Signature of Funerel Service Llc		Sali	isbury Cremat		/24/98	Salisu	ury, Ma	Tytaliu
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50,	tificate be axecuted ig physician and as the bunal-transit	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter UnderlyIng Ceuse (Disease or Injury that initieted events	•		,				1	
68760,	physic the b	Physician/Medical	thet initieted events resulting in deeth) Last	C.	Due to (or es	e consequenca of):					
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	To the Hospital or Attanding Pr within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exe	hyelclan: To the best of miner: On the basis of	of my knowled exeminetion	dge, deeth occurred et the ti end/or investigation, in my	me, dete end plece, opinion, deeth occur	end due to the ce red et the time, da	use(s) end me te end plece,	enner es steted. and due to the	cause(s)
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	-01	40	31. Date filed (Month, Dey, Year)	-	HOS B er's Signeture	yrn St., Ca	mbrilde	MD 9	1613		
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State of Maryland / Department of Health and Mental Hygiene

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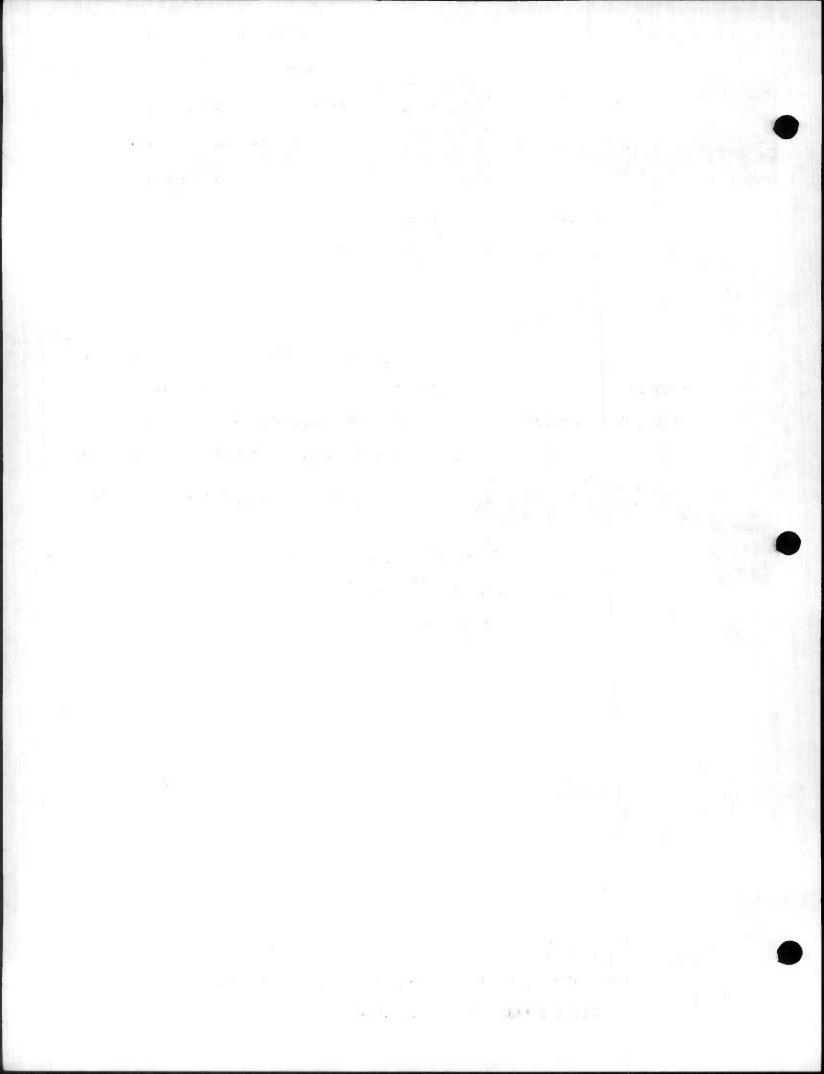
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State of Maryland / Department of Health and Mental Hygiene

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d other than "natural", or items event, the Medical Examiner in	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorcad	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:	in U,S.		edent of F ecify Cub	dispanic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Specify	ca - American Ind ck, White, etc. v: whi	
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State of Maryland / Department of Health and Mental Hygien

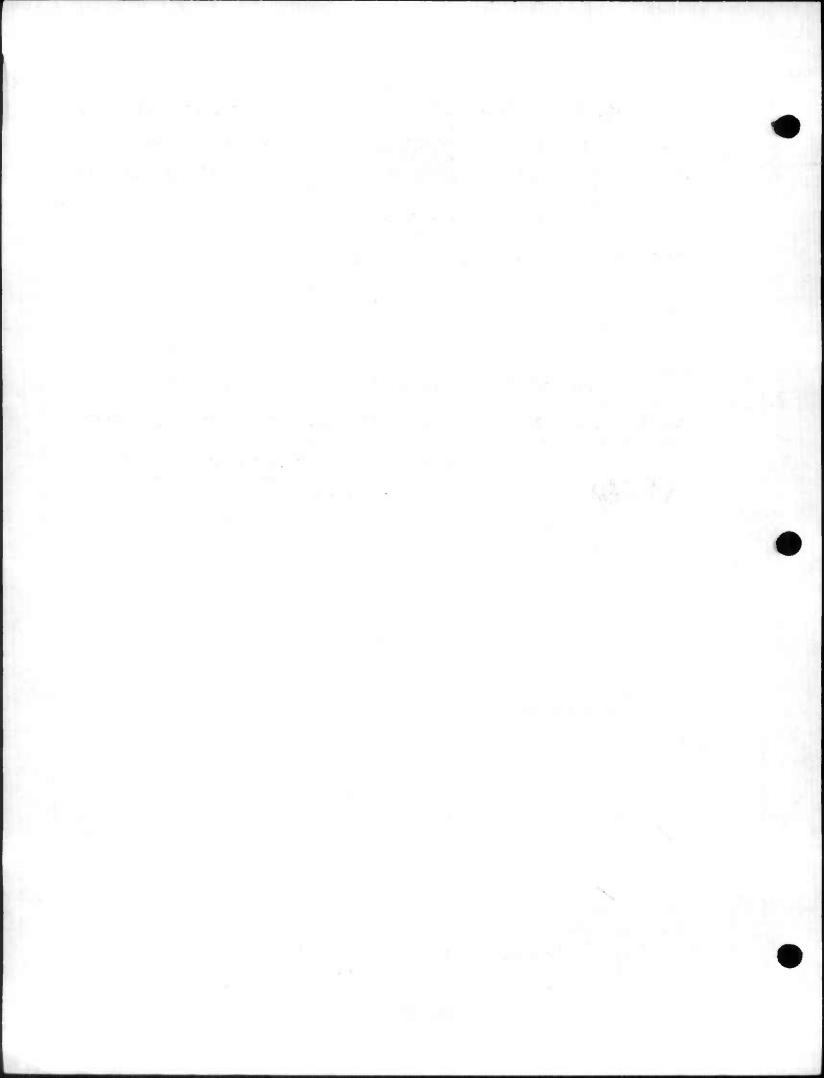
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician IRMA** LUCILLE KRICK FEBRUARY 23 1998 2:30 am /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 26, 1919 9. Birthplace (Stete or For Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign **Funeral** Days 1 M 200 78 170-12-0388 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hydiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, the Medical Exercises must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland St. Mary's 1 ☐ Yes 2 No Director Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20653 46350 Columbus Drive #1003 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🛣 No White þ 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Bualness/Industry Elementery/Secondery (0-12) College (1-4or 5+) Manufacturing Plant Floorlady 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Gruver Yeater Esther Harter 19a. informant'a Name/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 46350 Columbus Dr. #1003 Lexington Park, MD 20653 Leann Warner/Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State 2/27/98 McClure boro, PA 4 ☐ Donation 5 ☐ Other (Specify) McClure Union Cemetery 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funeral Service Licansee 1451 Dares Beach Rd. Prince Frederick, MD 20678 sewel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physiclan** immediate Cause (Final disease or condition resulting In death) /Medical Examiner (or as a consequence of Examiner that the daath certificata be axecuted attending physician and for usa as the burial-transit Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for as a con-P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): signed by the at d be datached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, ğ 24a. Was an autopsy performed? Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 ☐ Yes 2000 1 ☐ Yes 2 ☐ No certificata Hospital or Attending Physicien: 25. Was case referred to medical examiner? director Be 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Aftar this funaral 28a. Date of Injury (Month, Day Year) Certification: 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Netural 5 Pending daath. 2 🗆 No investigation 1 Yes 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by Direc 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled edicai 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated. 29a. Certifier 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature.

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Registrar

State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate of	Death			Reg. No.		100	_
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth **Physician** BURNETTA W. LONGFELLOW February 15, 1998 6:50 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Wilson Health Care Center Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) July 13, 1912 Maryland 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 10M 20F Months Deys Hours Yrs. Director 182-01-9430 85 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or thems 23s or 28s-f show any injury or other traumatic event, the Mental Examiner mass to 2008. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□Yes 2□No Director Gaithersburg Montgomery 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 20877 U.S.A. 301 Russell Avenue by Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Merried 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: 3 d Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry City of Philadelphia Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be George W. White Sarah Tilgham 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Lavinia W. Henderson - Sister 211 Russell Avenue, Gaithersburg, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) West Laurel Hill Cemetery 2-20 Lower Merion, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, DC 20011

tions that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death **Physician** /Medical immediete Ceuse (Finel month disease or condition resulting in deeth) Examiner Examiner 1/ con1 physician and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest alcter P.O. Box 68760. Physician/Medical Due to (or es e consequence of): attanding pl signed by the at d be datached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to certificate has been si irector, page 2 should Completed 24e. Wes en autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice Be 25. Wes cese referred to medical 28. Piece of Deeth (Check only one) Other: Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 1 Yes 20 No funaral 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Maturel injury 1 Yes 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical nplataly (Check only one) To the rithin 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name address of person who completed use of deeth (Item 23a) (Type, Print) R Russell 5,1 31. Dete filed (Month, Day, Year) 32 Registrar's Signeture State 7 Registrar

DHMH 16 Rev 6/95

199 Mindelle Marchelle

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month AWRENCE 12, 1995 4c. County of Deeth 4b. City, Town, or Location of Deeth WINNITRED /Medical 4e. Fecility Neme (If not institution, give street and number) Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) MAY 10, 19 5. Social Security Number 9. Birthplece (State or Foreign Country) JAMAI.CA 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF Director Yrs. 214-60-1707 58 Usuel Residence of Decedent flied within 72 hours aftar deeth with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Modical Examiner must be notified at 1 ☐ Yes 2X No Director MARYLAND PRINCE GEORGE'S HYATTSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2100 LEWISDALE DRIVE 20783 UNITED STATES Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes: 11. Maritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced BLACK Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry with and Mental Hygiena. 27 Is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) NURSE 12 HEALTH CARE Saltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) . Pages 1 end 2 should be fil ment of Heeith and Mental H lant: if item 27 is marked oth lury or other traumatic even Be IVAN LAWRENCE MAUDE PARRY 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MILLICENT LAWRENCE, SISTER 2107 CHAPMAN ROAD, HYATTSVILLE, MARYLAND 20783 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: if any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 2/17/98 BRENTWOOD, MARYLAND 21. Signeture of Funerel Service License 22. Name end Address of Fecility
FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final Acute Myocardial diseese or condition resulting in deeth) **Examiner** Physician/Medical Examiner The law requires that the death certificete be executed the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting In deeth) Lest Due to (or es e consequence of): Box 68760. Due to (or as e consequence of): P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Kenal Disease Division of Vital Records, þ 90 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? Malnutrition 1 ☐ Yes 2 Ø No 1 □ Yes 2 □ No certificata Hospital or Attending Physician: '24 hours after death.
 Funeral Director: After this certifical etaly filled in by the funeral director, I Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 \ Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated. 29e. Certifier Medicai To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Pour Oyan-36757 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 106 Irving St. N. W. # 411 Wash, D.C. 20010 31. Dete filed (Month, Day, Year) 32 Registrar's S 32. Registrar's Signature State FEB 1 8 1998 Registrar

The factor pages contact to the second conta Programme of the programme of the control of the co and the second second

WRC 98-0887-033 Please Type or Print in Black indelible ink. Assure All Copies Are Legible. LAKESHA N. State of Maryland / Department of Health and Mental Hygiene, LUCAS Certificate of Death Items: 23a part I,27 per MEO G-757 3/30/98 dh Reg. No: 2. Dete of Deeth 3. Time of Death 1. Decedant's Name (First, Middle, Last) Month Dey **Physician** 21, 1998 LaKesha Nicole Lucas FEB. 11:07 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner DOCTOR'S HOSPITAL Prince George's If Under 24 Hrs. 8 D If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min. 1 ☐ M 2/2 F Yrs. Cheverly, MD 213-25-8160 8 Director July 24, Usuai Residence of Decedent the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examinat nast be notified at NO 2 No Director New Carrollton Maryland Prince George's 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? permit. Pages 1 end 2 should be filed within 72 hours effer deeth with 1 Department of Health end Mentel Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 2 any injury or other treumatic event, the Westerl Exercises 2002. 20784 8625 Annapolis Road, #202 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritel Stetus Black, White, etc. 1X Nevar Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: by Black 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Sacondary (0-12) Collaga (1-4or 5+) Student Public School 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Wayne Josey Casonya S. Lucas 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) 19e. informent's Neme/Relationship (Type, Print) Casonya S. Lucas - Mother 8625 Annapolis Road, #203, New Carrollton, MD 20784 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 2/26/98 Harmony Memorial Park Landover, MD 22. Name and Address of Fecility 21. Signature of Euneral Service Licensee STEWART FUNERAL HOME, Inc. 23. Art1. Enter the disease, or complications that caused the daeth. Do not antar the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. D. C. Approximata Intarval Between Onsat and Death **Physician** /Medical Immediate Ceuse (Final disease or condition rasulting in death) INTRA-CEREBRAL HEMORRHAGE Examiner Dua to (or es a consequance of) Examiner physician and s the buriel-trensit thet the death certificete be executed Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Ceuse (Diseesa or Injury thet initieted evants rasulting in death) Lest Dua to (or as a consaquance of): Box 68760, Physician/Medical Due to (or as a consequance of): signed by the e Pert II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Part I. 23b. Did tobecco use contribute to the cause of death? P.O. 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of daeth? Completed 24a. Wes en eutopsy peen 1 Yes 2□ No 10XYes 2 No or Attending Physician: effer death. Director: After this certific Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1XX es 2 No 1 ☐ Inpatient 2 XER/Outpetient 3 ☐ DOA funeral 28e. Dete of injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 1 XX laturel 5 Pending 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homicide e Hospital 1 Certifying Physician: To tha best of my knowledge, death occurred et the tima, data and place, and dua to the ceuse(s) end manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred et the time, data end place, end dua to the cause(s) end manner stated. 29a. Certifian Medical (Check only one) To the To the 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 29c. Licanse number

State Registrar Strphyn S.
31. Dete filed (Month, Day, Yeer)

27

Radentz 111 Penn Street, Baltimore, Maryland 21201

30. Name end eddress of person who completed cause of death (Itam 23a) (Type, Print)

O.C.M.E.

FEB. 23, 1998

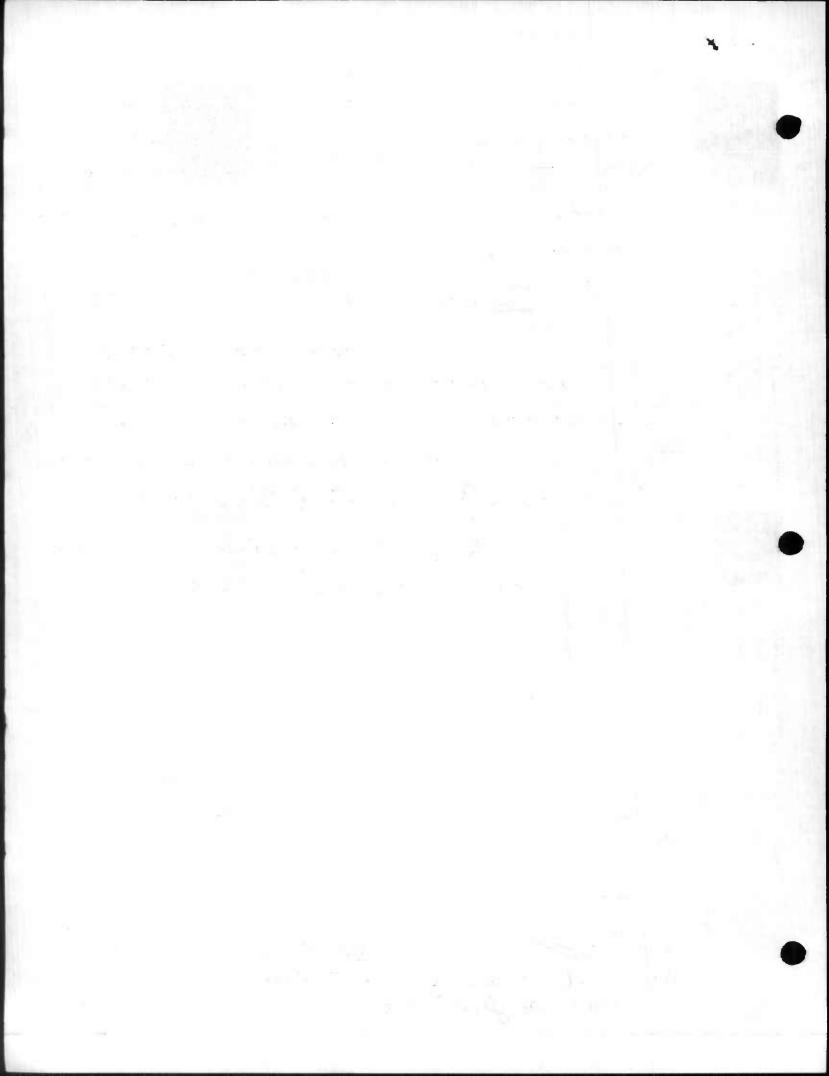
FEB \$7 898 (St. S. Sec. Rode)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** PRESTON MEREDITH CALVERT 3:00 pm 22 1998 February /Medical 4b. City, Town, or Location of Deeth 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 2710 Toddville Road Toddville Dorchester If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplace (Stata or Foraign Country) **Funeral** Days 218-20-6761 71 Yrs Director Oct. 16 1926 Maryland Usual Rasidance of Dacedant with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or frems 23a or 28a-f show treumatic event, the Mexical Examiner must be notified at MD Dorchester Toddville 1 □ Yas 20 No Director 10g. Citizan of What Country? 10e. Street and Number 10f, Zip Coda 2710 Toddville Rd. 21672 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vant of Health and Mantal Hygiena. Int: If Hem 27 Is marked other than "naturel", or Hems 23. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1274s 2 □ No WYas, Giva Year or Dates:1 953-55 14. Race - American Indien, Bleck, Whita, etc. Wes Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Nevar Merried 2 Married 1□ Yes 2010 Baltimore, Maryland 21215-0020 p Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Dacedent's Education (Specify only highast grade complated) 16b, Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) waterman - grocer self employed 18. Mothar's Nama (First, Middla, Meidan Sumama) 17. Father's Name (First, Middle, Last) McGlaughlin Preston Franklin Meredith Madeline 2 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Patsy B. Meredith - wife 2710 Toddville Rd., Toddville MD 21672 other t 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from Stata injury or 4 ☐ Donetion 5 ☐ Othar (Specify) Dorchester Memorial Park 2-26 Cambridge, Maryland 21. Signature of Funaral Sarvice Licensee 22. Name and Addrass of Facility Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one ceuse on each line. **Physician** /Medical Immediata Causa (Final disease or condition resulting in daath) Examiner Examiner physician and s the burial-transit Sequantially list conditions, if any, laading to immediata ceusa. Entar Undarlying Cause (Disaese or Injury that Initiated evants rasulting in daath) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequance of): USB been signed by the atter should be datached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contributa to the cause of death? Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 Yes No 1 Yas this cartificata To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this cartifica complataly filled in by the funeral director; p Be 25. Was cesa raferred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4□ Nursing Homa Rasidanca 6 □Othar (Specify) 1 Yas 25 No Certification: To 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Magnar of Daath 28d. Dascribe how injury occurred 28b. Tima of Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accidant invastigation 6 Could not be datarmined 3 Suicida 28e. Place of Injury - At homa, farm, straet, fectory, offica building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 4 Homicida 29a. Certifier 🔁 Certifying Physician: To the bast of my knowledga, daath occurred at tha tima, date and plece, and due to the ceuse(s) and mannar as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at tha time, date and placa, and due to the causa(s) and menner stated. 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signad (Month, Day, Year) 30. Name and address of person who complated ceuse of deeth (Itam 23a) (Type, Print) State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 10a. P.G.C. 2-20-98 cr 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Physician /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street and number) Examiner 7. Age (In yrs. lest birthday) 9. Birthpiece (State or Foreign **Funeral** 10M 20F Director 0 32 permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hyglene. Important: If items 23 a or 28e-f show any injury or other traumatic avant. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo N/A 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? USA 1022 OTIS STREET NE 00 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bieck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Never Merried 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 BLACK 1 ☐ Yes 2 🗓 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lift RUCK UPREFACE. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry GOVERNMENT Elementery/Secondary (0-12) Coilege (1-4or 5+) NONE GOVERNMENT EMPLOYEE 3RD GRADE 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) LELAR HINES CLEVELAND MACK, SR. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA McLAIN(DAUGHTER) SAME AS 10A, B, C, D, E, &F 20e. Method of Disposition

1 ☐ Burlei 2 ☐ Cremetion 3 ☐ Removel from State 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 2/21/98 BRENTWOOD, MD. FT LINCOLN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Eachilly. RHINES CO,. INC. 21. Signeture of Funeral Service Licenses 3030 12TH ST NE, DC 20017 23e. Par . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medicai BRAIN METASTATIC CANCER

Due to (or es e consequence of):

MELANDMA Immediate Cause (Fine disease or condition resulting in deeth) Examiner Examiner been signed by the attending physicien and should be deteched for use es the buriel-transit The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably #☐ Unknown à 24b. Were autopsy tindings aveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? hes After this certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time ot 28c. Injury at Work? 28d. Describe how injury occurred Neturai 5 Pending investigation 1 Yes 2 No 2 Accident

Division of Vital Records, P.O. Box 68760

filled In by the funeral To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun.

State Registrar

RATMOND MWADIUKO, MD

ATTENDING

29c. License number

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piace, end due to the cause(s) end menner steted.

29d. Dete signed (Month, Dey, Year)

28t. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

(Type, Print) 7221 B HANDVER PARKWAY (REFUBER

28e. Piece of Injury - At home, ferm, street, tactory, offica building, etc. (Specify)

31. Dete tiled (Month, Day, Year)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

Medical

4 I Homicide

FEB 20 1998

6 Could not be



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 2/18/98 03:25 AM JOHN WILLIAM MICKLES 4b. City, Town, or Location of Death 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) ¥ M 2□ F Months Deys Hours 226-18-9151 81 Yrs. Oct. 18,1916 RUSSBURG. VA. Usual Residence of Deceden 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits VA **ALEXANDRIA ALEXANDRIA** Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 22303 USA 6034 RICHMOND HIGHWAY #203 12. Wes Decedent Ever in U,S. Apmed Forces? 1€1 Yes 2 □ No If Yes, Give Yeer or Detes: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien AFRO-MMERICAN ARMY 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Flementery/Secondary (0-12 7TH GRADE College (1-4or 5+) PRIVATE INDUSTRY BARBER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JOSEPHINE TOSH THOMAS JASPER MICKLER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5929 KANSAS AVE NW, WASH, DC 20011 MARCIA MICKLES-JOHNSON 20b. Piece of Disposition (Name of cemetery, cremetory or other piece 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 2/21/98 ALEXANDRIA, VA. MT COMFORT CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name end Address POHN'ty T. RHINES CO., INC. 3030 12TH ST NE, DC 20017 23a. Part. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Ceuse (Final diseese or condition resulting in deeth) Rena(Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): obstanct 10~ Due to (or es e consequenca of) prestate CANCES Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

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31. Dete filed (Month, Day, Year)

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25. Wes case referred to medical exeminer?

1 Yes 2 No

27. Manner of Deeth

Neturel

2 Accident

3 Suicide

29e. Certifier

4 Homlcide

(Check only one)

Hospitei:

28e. Dete of Injury (Month, Dey Year)

5 Pending investigation

6 Could not be determined

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32. Registrer's Signature The Michael Real H

1/ Inpatient 2 ER/Outpatient 3 DOA

28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28b. Time of

28c. Injury at Work?

🚧 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medicat Examtner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

29c. License number

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February 39372 INTANcause of deeth (Item 23e) (Type, Print) SIRVUSPAIZ SIFY SUIT 324

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

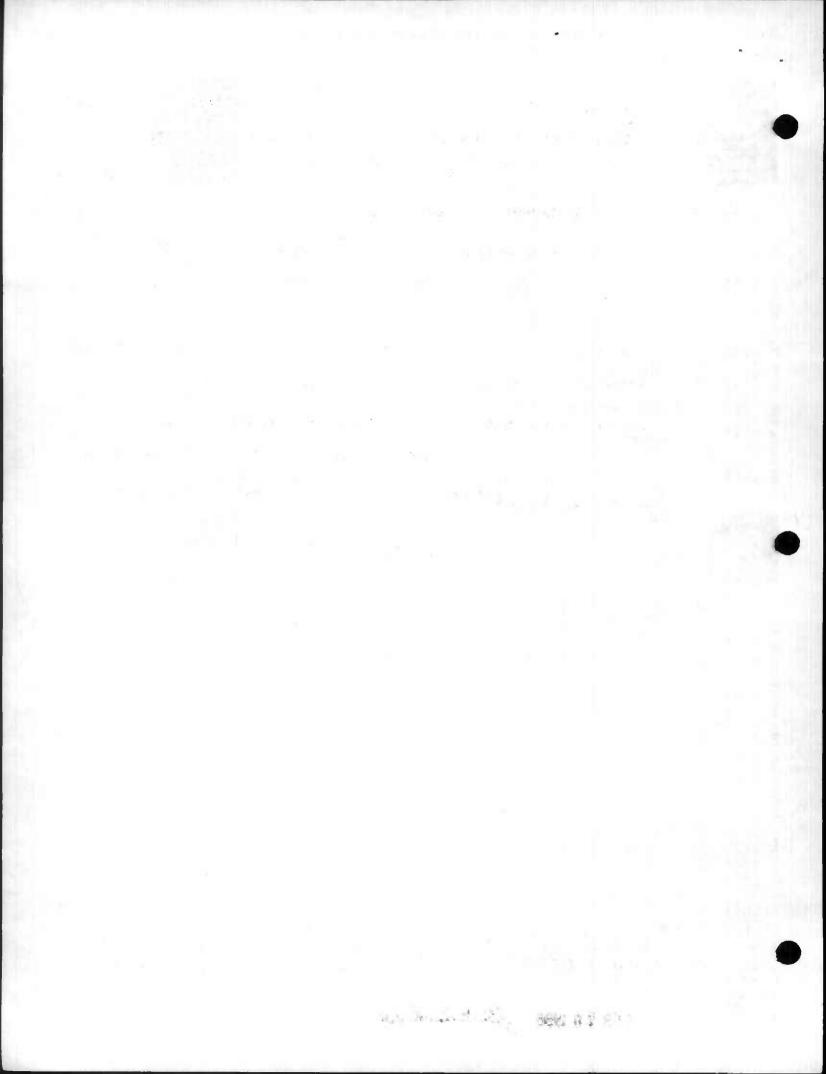
1 Yes 2 No

28d. Describe how Injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

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Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Deeth 3. Time of Death **Physician** MASON ARENCE rebruaru /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LANHAM If Undar 24 Hrs. DOCTORS HOSPITAL PRINCE GEORGE'S 7. Aga (In yrs. last birthday) If Undar 1 Yaar 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) 9. Birthplace (State or Foraign **Funeral** M 2□ F Days 219-12-4362 1924 MARYLAND 73 Yrs. DEC. 10, Director 10a Stata 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yas 2 □ No Director MARYLAND PRINCE GEORGE'S LANDOVER 10e. Street and Numbe 10f. Zip Coda 10g. Citizen of What Country? ò 1836 RAY LEONARD RD. 20785 items 23a UNITED STATES Funerai 12. Wes Decedant Evar in U,S. Armad Forces? 1 Yes 2 No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amaricen Indien, Bleck, Whita, atc. 11. Marital Stetus 1 □ Nevar Marriad 2 □ Married ò Maryland 21215-0020 If Yas, Giva Yaar or Datas: 1 Yes 2 No Specify: þ Specify: BLACK 3 Widowad 4 □ Divorced "naturel". Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Businass/Industry reges 1 and 2 should be filed within 72 tent of Health and Mantal Hygiena. Int: If Item 27 is marked other than "net by or other traument. (Specify only highast grada complated) PRIVATE Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be Pages 1 and 2 should be nent of Health and Mantal JOHN MASON LILLIAN WILSON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 16300 BROOK TRAIL CT. UPPER MARLBORO, MD. 20772 SYLVIENE MASON/ DAUGHTER Baltimore, 20a. Mathod of Disposition

Burial 2 Crametion 3 Ramoval from Stata 20b. Placa of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, Stata permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Othar (Specify) RESURRECTION CEMETERY 2/21/98 CLINTON, MD. 21. Signeture of Eunaral Service Licenses 22. Nama and Addrass of Facility ALEXANDER S. POPE FUNERAL HOMES M1085 5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747 23a. Part1\Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onsat and Death **Physician** Septic shock
PNEUMONIA Immediata Causa (Final disaasa or condition resulting In daath) /Medicai Examiner Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Disease or injury that initiated events resulting In daath) Lest MULTIPLE MYELOMA Division of Vital Records, P.O. Box 68760. Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings evailabla prior to complation of ceuse of death? Completed 24a. Wes en autopsy performed? cartificate 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Attending Physician: 25. Was cesa rafarrad to medical examinar? Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Residance 6 Othar (Specify) 1 Yes 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Aftar 1 Natural 5 Pending death. invastigation 1 Yas 2 No 2 Accident after death in by the 3 Suicide 6 Could not be datarmined 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 8 To the Hospital within 24 hours a To the Funeral Completaly filled 1 Certifying Phyaician: To tha best of my knowledge, daath occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

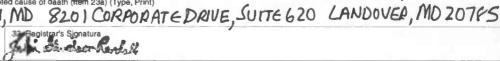
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, data and place, and dua to tha ceuse(s) and mannar stated. edicai 29a, Certifian 29b Signatura end the of certifian 29c. Licansa number 29d. Date signed (Month, Day, Year) February 16, 1998 ma and address of person who completed cause of death (ttern 23a) (Type, Print)

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31. Data filed (Month, Day, Yaar) State FEB 1 9 1998 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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	ons 23	Funeral	11. Marital Status	12. Was Decedant Armed Forcas?	Evar in U,S	. 13.	Was Decedent of	Hispanic Origin? (Specify Yes or No- rto Ricen, atc.)		e - Amarick, White,	cen Indian,
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ó	afte Dir	ert	4 Homicida	building, ato	: (Specify)				City or Town	n, Stete)		
	To the Hospital or Attending within 24 hours after deeth. To the Funeral Director; Aft completely filled in by the fur	alc	29a. Certifier 1 Cartifying F	hysician: To tha best o	of my know	ledga, daath	occurred at the	tima, date and oler	e, and dua to the or	ausa(s) and ma	nner as s	iteted.
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FEBRUARY 14, 1998

Physician /Medical Examiner

Funeral Director

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Baltimore, Maryland 21215-0020 merked other Pages 1 and 2 should be 1 traumatic item 27 permit. Pages Department of Important: If it any injury or o

Physician /Medical Examine

physician end s the buriel-trensit The law requires that the death certificate be executed attending pl signed by the a should ils certificata has I

Box 68760 Division of Vital Records, P.O. l or Attanding Physician: after daeth. Director: After this certifica funeral 9 24 hours (Hospital pletely

To the Vithin 2 To the I

1. Decedant's Nama (First, Middla, Last) Tima of Death Month Year JAMES EDWARD McDOWELL, Jr. FEBRUARY 13, 1998 1820PM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) JOHNS HOPKINS HOSPITAL PICU BALTIMORE CITY If Undar 1 Year | If Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foreign Country) Min Months Days Hours 1☑M 2□F Yrs. Jan. 13, 1998 216-51-5805 Annapolis, MD 1 Usual Rasidence of Dacedant 10d. Insida City Limits 10a. Stata 10b. County 10c. City, Town or Location 1 No Yes 2 No Directo Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? United States 21144 Funeral 1843 Arwell Court 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva Year or Datas: 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) Black, Whita, etc. 1 Navar Marriad 2 ☐ Married Specify: Puerto Rican 1⊠ Yas 2□ No à 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Spacify only highast grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) N/A N/A N/A 18. Mothar's Name (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middle, Last) James Edward McDowell, Sr. Ruby Valentin 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Ruby Young - Mother 21144 1843 Arwell Court, Severn, MD 20b. Place of Disposition (Nama of cemetary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 € Burlal 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 2/20/98 Landover, MD Harmony Memorial Park 22. Name and Addrass of Facility 21. Signature of Funeral Service Licanses STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D.C.

Approximately the design of t Approximate Intervat Between Onset and Death Immediate Cause (Final disaasa or condition resulting in daath) Examiner Sequentially list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Disaase or Injury that initiated avants rasulting in death) Last Dua to (or as a consequanca of): Physician/Medical Dua to (or as a consequence of) 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to 24a. Was an autopsy Completed complation of cause of death? 1X Yas 2 □ No Yas 2□ No 25. Was case refarrad to medical Be 26. Placa of Death (Chack only ona) axaminar? Hospital: 1 ⊠Inpatiant 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 2 1 Yas 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of Certification: Starrs 5 Panding invastigation father with body Injury 1 Natural 28a. Place of Injury - At homa, farm, straet, factory, offica building, etc. (Specify) 1 Yes 2 No 2. Accident 3 ☐ Suicida 6 Could not be determined 281. Location (Streat and Number or Rural Route Number, City or Town, State) 1843 Awwly Cowt, SeVAN 4 - Homicide Home 1 Certifying Physician: To the best of my knowladga, death occurred at tha tima, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edica (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

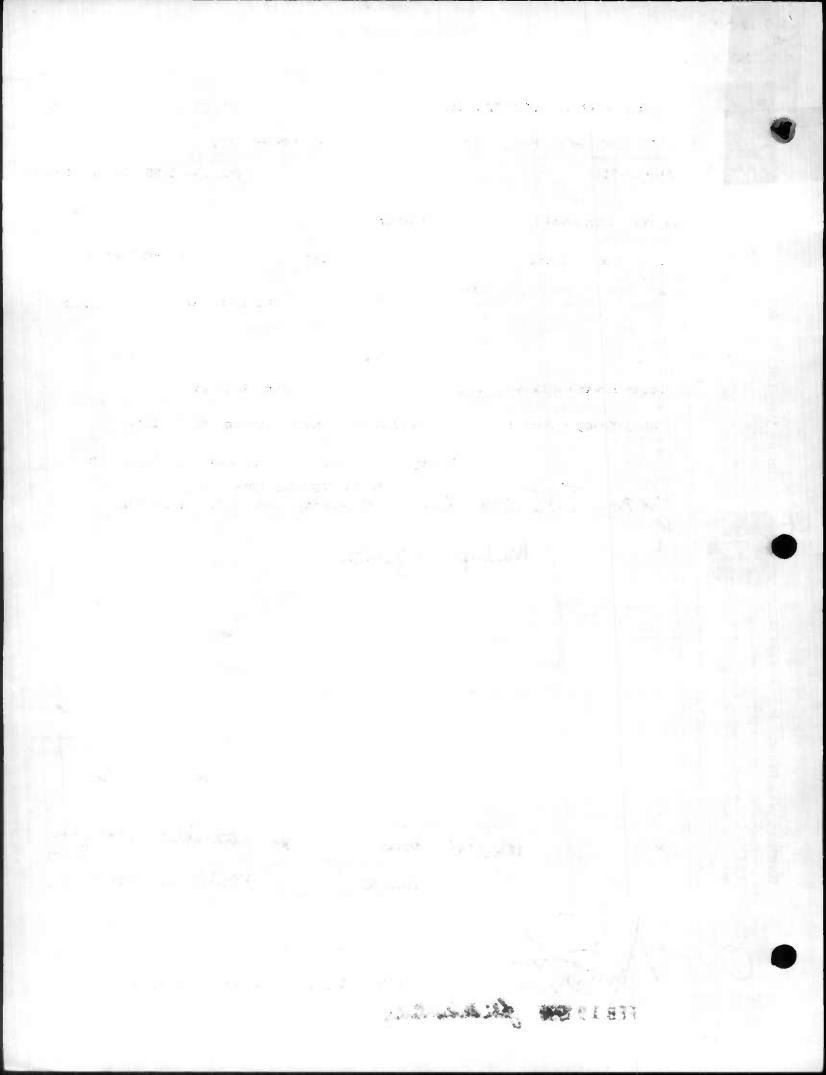
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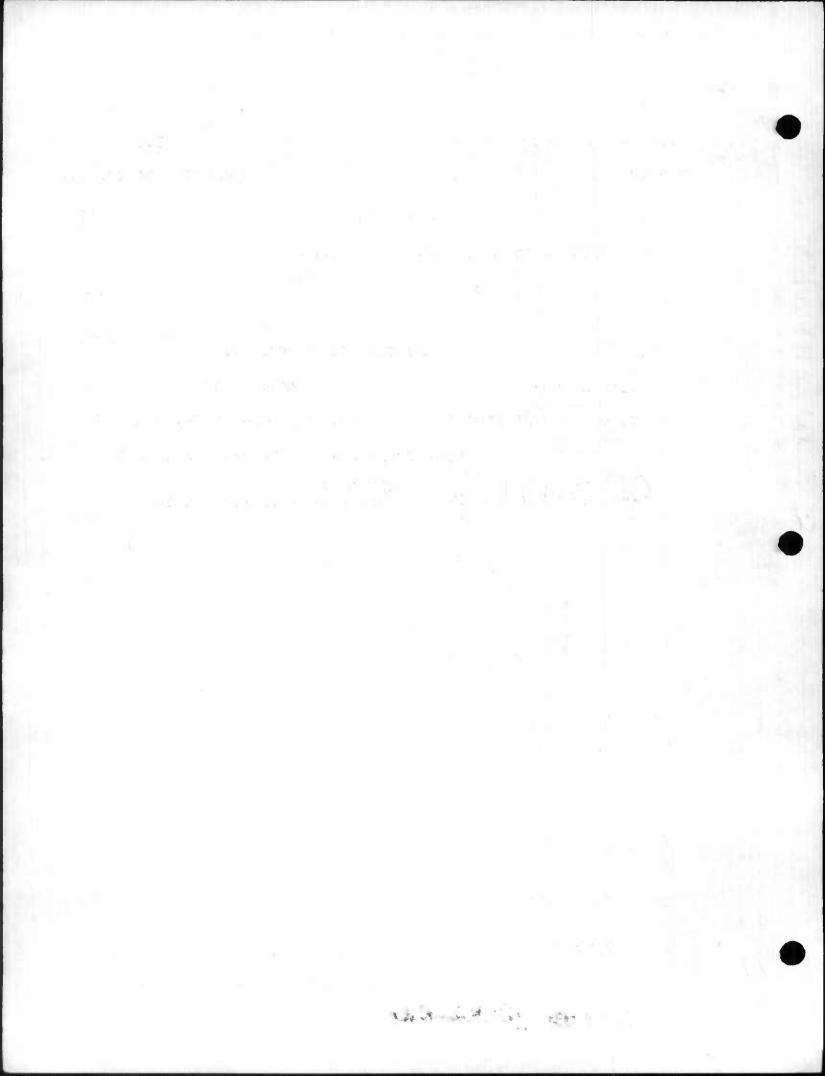
Day, Year!



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death **Physician** FEBRUAR SUSAN MAYERS /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner DOCTORS COMMUNITY HOSPITAL LANHAM 7. Age (In yrs. lest birthday)
95 Yrs.

H Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey. Year)
Hours Min. March 16 1902 VIRGINIA 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1□M 2√2F 578 20 9494 **Director** Usuel Residence of Decedent r 28a-f show a notified at 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits D.C. WASHINGTON 1 Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ris 23a or i 2803 NORTH CAPITOL ST. N.E. 20002 Nems 23a USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Yes 2 XNo Specify: Specify: BLACK þ 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry FED. GOVT. Elementery/Secondery (0-12) College (1-4or 5+) MAINTENANCE SUPERVISOR 12 marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be and Mental MARY A BROOKS WILLIAM G. DEAN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ADA C. GRIFFITH/DAUGHTER 1510 FIRST ST., N.W. WASH. D.C. 20001 Health important: If Item 27 any injury or other tr 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stafe B 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete ROCK CREEK CEM. 2/20/98 WASHINGTON, D.C. 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility WATSON F. H. 3435 14th ST., N.W. 20010 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 2 Weeks Examiner Due to (or es e consequence of) meumana Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated evenfs resulting In deeth) Lest Due to (or es e consequence of): Failure P.O. Box 68760, Physician/Medicai Pert II. Other significant conditions confributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Coronaux artery disease 1 Yes 2 No 3 Probably 4 Unknown be del Records. þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en sutopsy performed? Seizure Disorder 1□ Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certific 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To filled in by the funeral 28e. Dete of injury (Month, Dey Year) 27. Menger of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homlcide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 fo the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D0052119 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) SRIDHAR CHATRATHI, Swife 302; 8100 Good Luck Rd; Lanham, MD
Deterfiled (Month, Day, Year) 32, Registrer's Signeture 31. Dete filed (Month, Day, Yeer) Selli Mindson R Registrar FEB 1 9 1998



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth Month Year **Physician** Frances Ruby Main February 19, 1998 0705 /Medical 4e. Fecility Neme (If not institution, giva street and numbar) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Calvert Manor Healthcare Center Cecil Rising Sun If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthpleca (Stata or Foraign Country) **Funeral** Deys Hours 1□M 250 F Yrs. Director 212-26-4153 August 14,1925 Maryland Usuel Residance of Decedent the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notified at 14 Yes 2 □ No Director Maryland Cecil Elkton 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 202 Locust Lane 21921 United States death v Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Detes: 14. Raca - American Indian, Bleck, White, atc. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygione. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exemptor 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 E No Specify: Specify: g 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) Public School Baker System 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Mamie E. Dennison Daniel Leon Ewing 19a. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Earl G. Main Jr./Son 811 Marley Road, Elkton, Maryland 21921 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata Data 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donation 5 ☐ Other (Specify) Feb.23,1998 Union Cemetery Union, Maryland 21. Signature of Funeral Service Licenses 22. Neme end Address of Facility Hicks Home for Funerals, P.A. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest,

Approximate

Appro Approximata intervel Between Onset and Deeth **Physician** /Medical immediate Cause (Final aute mount sufale disaesa or condition resulting in deeth) Examiner Due to (or es a consequenca of): Examiner acol my cand ician and buriel-transit Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Ceuse (Disease or injury the initiated events resulting in deeth) Lest Due to (or es e consequance of) physician as the buriel Drules mean Box 68760 certificeta be Physician/Medical Dua to (or es a consequenca of): HEVA esn 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. been signed by the should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings aveileble prior to completion of cause of deeth? Completed 24a. Wes an eutopsy performed? page 2 20 No 1 Yas 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affar this certifica completely filled in by the Iuneral director, i. 25. Was case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 | Inpatianf 2 | ER/Outpatienf 3 | DOA Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 27. Menger of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: 1 Neturei 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No invastigation 6 Could not be datarmined 3 Suicide 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete) Pleca of Injury - At homa, farm, street, factory, office building, etc. (Spacify) 4 Homicide 1 Certifying Physician: To the best of my knowledga, death occurred et tha tima, data and place, and due to the causa(s) end menner es steted.
2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner sfeted. edicai 29a. Certifiar (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) February 20, 1998 Jun chin Han MA DO4823 10 30. Name end address of person who completed cause of daeth (Itam 23a) (Type, Print) 223 W. Main St. Elkton, MB 21921 mio Jui-Chih Hsu, 1 32. Registrar's Signature 12 State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** KATIE MCNULTY FEBRUARY 6, 1998 9:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** 4c. County of Death BERLIN NURSING & REHAB. CENTER BERLIN WORCESTER If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 24 Hrs. Date of Birth (Month, Dey, Year) 5-29-02 9. Birthplece (State or Foreign Country) **Funeral** Deys 1 🗆 M 95 Months Hours Min 207-26-5290 Director IRELAND Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City. Town or Location 28a-f show 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be northed at MD. WORCESTER **Funeral Director** OCEAN CITY 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 142ND STREET 21842 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter to Depertment of Health end Mental Hygiene. Important: if frem 27 is marked other than "natural", or frem any Injury or other traumatic evant. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced Specify: Year or Dates: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) GROCER RETAIL FOOD 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be THOMAS HENNIGAN To NORAH MCNULTY 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Nora Polchan 134TH STREET CITY, MD., 21842 OCEAN 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Bemoval from State HOLY SEPULCHRE CEM 2 - 104 ☐ Donetion 5 ☐ Other (Specify) ROXBORO, 22. Name and Address of Fecility ULLRICH FUNERAL HOME BERLIN, Mp., 21811 in the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, heart fallure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical ATTEROS CUENOTIC GONDIOVASCUM DIE Examiner Physician/Medical Examiner HUPERTENSION The law requires that the death certificate be executed ettending physician end for use es the burief-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by the page 2 should be detached 1 Tes 2 No 3 □ Probably 4 □ Unknown by 24b. Were autopsy findings aveitable prior to completion of cause of death? Completed 24a. Was an eutopsy performed? After this certificate has been 1 Yes 2 No 1 ☐ Yes 2X No or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 I Homicide To the Hospital or within 24 hours of To the Funeral D **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

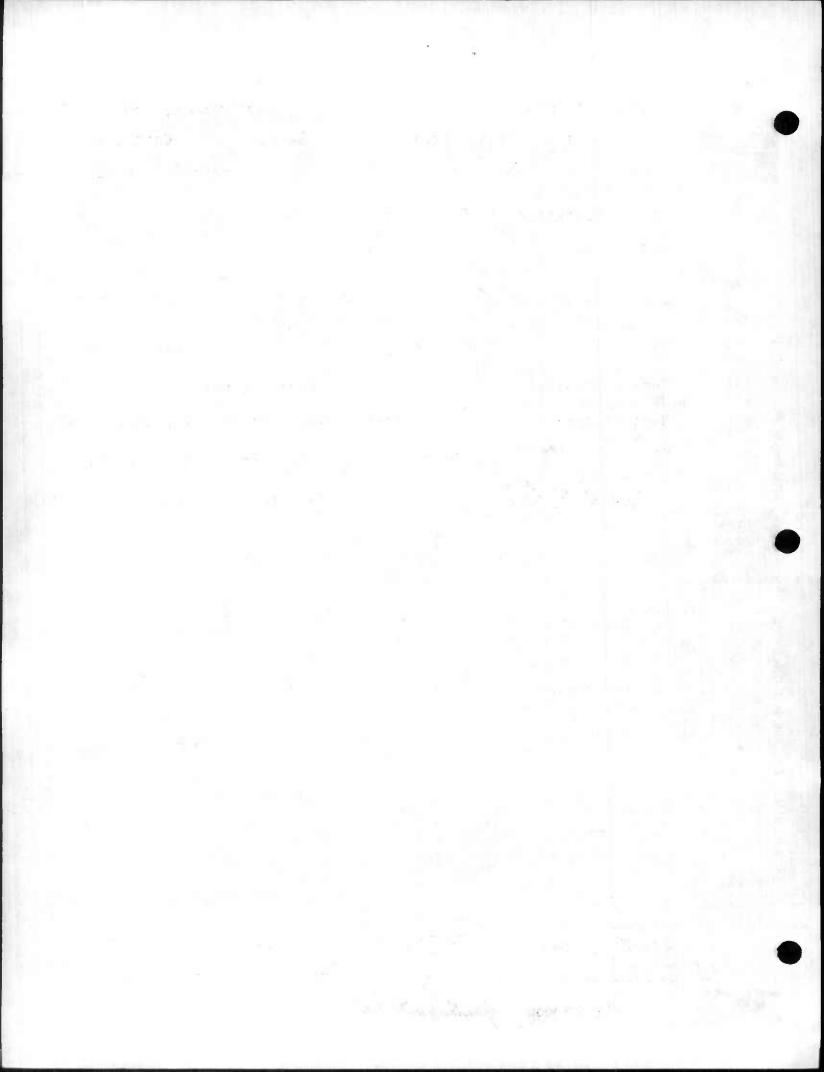
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only onel 29b. Signatury and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 1246252 cer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BENEIN, MDZ 1811 314 FRANKOUN AVE AU173 302

Registrar

State

31. Date filed (Month, Dey, Year)
FEB 0 9 1998

32. Registrar's Signature
Julia Davidson-Randall



State of Maryland / Department of Health and Mental Hygiene

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Physicia	an	1. Decedent's Name (First, Middle,	_		EDMOTT		2. Date of D Month	eeth Day	3. Tim	e of Dea
/Medic	_	ELLEN			ERMOTT		FEBRU		998 17	20
Examine	er	4e. Fecility Neme (If not institution, g		7)			, or Location of Dea			
		177 WINDJAMM	ER RD.			OCEAN	PINES	WORC	ESTER	
Funeral Director		213-30-0274	Sex 7. A	ge (In yrs. last	birthday) If Under 1 Months C		Hrs. 8. Date of B Min. 2-29	irth = 28	9. Birthplece (Sta	ate or F
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23a or wat be	ral Dir	177 WINDJAMM			10f. Zip Co	811		USA	of What Country?	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Data of Death 3 Time of Death Month GEORGE RAYMOND MALLET! 2 12:30 Am 4e. Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Worcester Berlin Atlantic General Hospital If Under 24 Hrs. Hours Min. 5. Social Sacurity Number If Under 1 Year 7. Aga (In yrs. last birthdey) 9. Birthplaca (Stata or Foreign Country) Months Deys 10XM 20 F 100-12-5527 Yrs 72 Usuel Residence of Decedent 10a. Stata 10c. City, Town or Location 10d. inside City Limits Ocean city Worcester 1 Yes 2□ No MD 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 21842 413 Baltimore Ave. 12. Wes Decedent Ever in U,S. Armed Forces? 12. Was 2 □ No If Yes, Give Yeer or Detes: WW Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, 11. Meritel Status Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yas 💥 No Specify: Specify: white WWII 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Steel Co. Steel Worker 12 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Margaret Lash Frank Malleti 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 413 Baltimore Ave. Ocean City, MD 21842 19e. informent's Neme/Reletionship (Type, Print) Frances Malleti/ Wife 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 200 cremation 3 ☐ Removel from Stete Cape Henlopen Crematory 2/16/98 Frankford, DE 4 □ Donation 5 □ Other (Specify) 22. Nama and Address of Fecility Burbage Funeral Home 108 William St. Berlin, MD 21811 polications that coursed tha deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, one cause on post line. Approximete intervel Between Onsat and Deeth immediata Causa (Finel diseese or condition resulting in deeth) obstructive pulmoszny disease chronic 10 years Due to (or es a consequença of) Dua to (or as a consequence of): Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Pres 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes an eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medicai Examiner

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permit. Pages 1 and 2 Department of Health a Important: If item 27 is

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Division of Vital Records, P.O. Box 68760,

Examiner Sequentielly list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Lest Physician/Medical

PNEUMOSIA

25. Wes case referred to medical examiner? 1 Yas 2 No

Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 28d. Describe how injury occurred

27. Menner of Deeth 1 Netural 2 Accident 3 ☐ Sulcide

4 Homicide

28e. Dete of injury (Month, Dey Year) 5 Pending invastigation 6 Could not be determined

Hospital:

30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

Robert Durlles 9733 Herinary

28c. injury at Work? 1 Yes 2 No 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifie (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) and manner stated. 29c. Licensa number

29b. Signature and title of cartifiar Dhysiul

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State Registrar 31. Dete filed (Month, Dey, Year)

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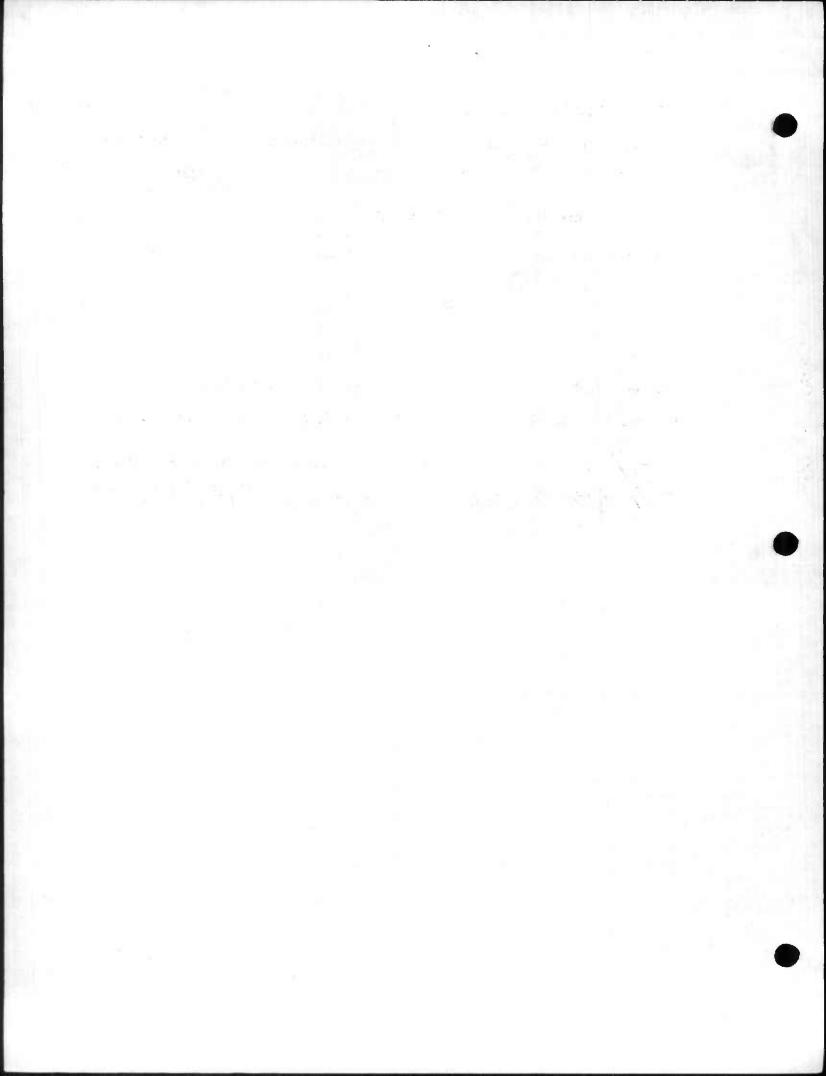
32. Registrer's Signeture Julia Davidson-Randoll

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

DHMH 16 Rev 6/95

29d. Date signed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene

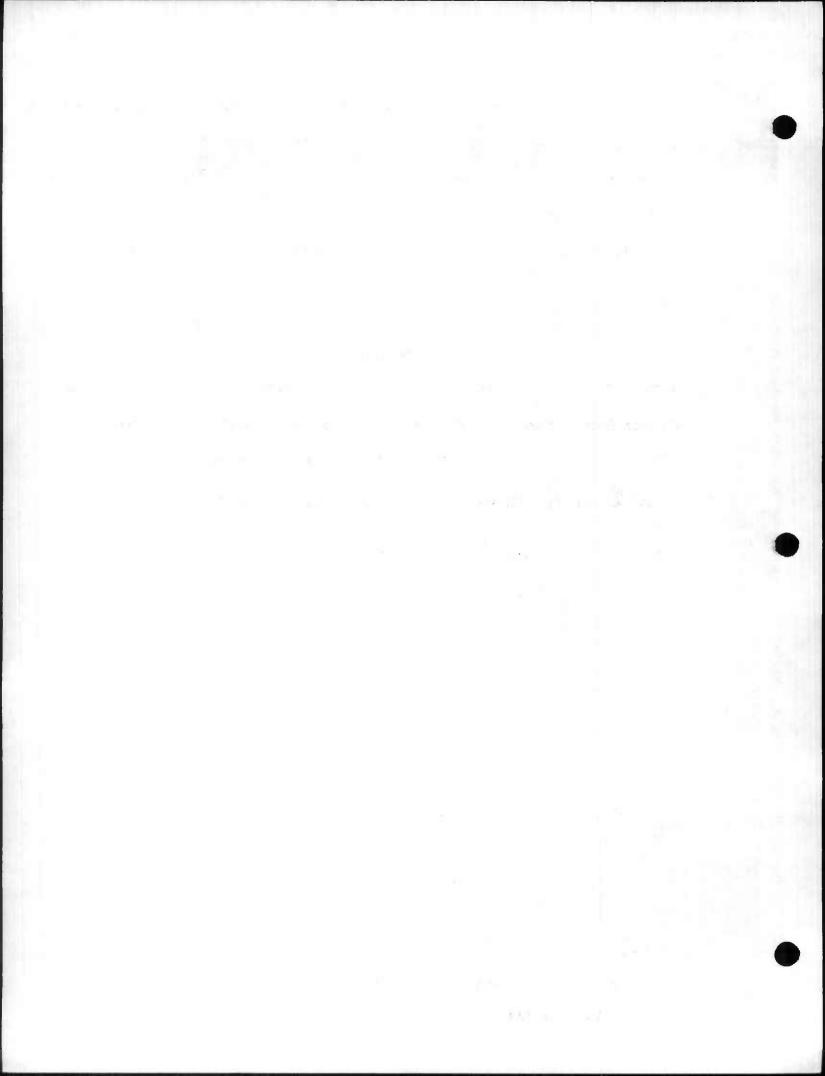
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** LILLIAN MAY MCCONKEY FEBRUARY 18,1998 17:20p.m. /Medical 4a. Fecility Neme (If not Institution, give street and number, 4b, City, Town, or Location of Deeth 4c. County of Deeth Examiner Calvert Memorial Hospital Prince Frederick Calvert 8. Dete of Birth (Month, Day, Year) July 17, 1 5. Sociel Security Number If Under 1 Yeer | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 200 F Months Deys Hours Min Yrs. Director 578-09-3460 83 1914 Washington, D.C. Usual Residence of Decedent the Marylend 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other then "natural", or flems 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at Maryland Calvert North Beach 1M Yes 2 No Director 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with 3943 7th Street 20714 USA Funeral 11. Marital Status 12. Was Decedent Ever In U.S. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Dates: should be filed within 72 hours aftar ond Mentel Hygiena.

marked other than "natural", or Hea 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify 3 ₩ Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) housewife own home permit. Pages 1 and 2 should be file.
Department of Heelth and Mentel Hy
Important: If Item 27 is marked other
eny injury or other traumatic event 17. Fether's Neme (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Charles Н. Krammer Lillian Trego 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Donald McConkey / son Brewster Lane, Waldorf, MD 4006 20b. Pieca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State Cedar Hill Cemetery 2-21-98 4 ☐ Donetion 5 ☐ Other (Specify) Suitland, MD 21. Signeture of Funeral Servica Licansee 22. Name end Address of Fecility llain Rausch Funeral Home, P.A., Owings, MD 20736 23a. Pert1. Enter the disease, or complication, thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Mron Examiner Due to (or es e consequence of) Examiner burial-transit requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest end Due to (or es e consequence of): P.O. Box 68760, ettanding physician Physician/Medical the Due to (or es e consequenca of) USB as signed by the d Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 PYes 2 No 3 Probably 4 Unknown Division of Vital Records, by Completed 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy peen completion of cause of death? The law page 2 After this certificate has 2 1 No 23 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifice Be 25. Wes case referred to predicts 26. Plece of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 N 2 1 ☐ inpatient 2 DER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) end menner es stated.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29a. Certifier Medical **SOMPlataly** (Check only 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) umerle abelon 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 15 Dr. Kioumarce Yazdani, M.D. Huntingtown, Maryland 20639 31. Date filed (Month, Day, Year) 32. Registre 's Signature State 1998 > Falia Davidson Rardall FEB Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8:55a.m. MARY HENRIETTA MCCAFFREY Feb 19, 1998 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Carroll County General Hospital Carrol1 Westminster If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) Months Deys 1□M 2√2F 219-30-8685 85 Yrs. 3, 1913 Maryland Jan. Usuel Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MD Carroll Westminster 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21157 661 Ridge Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No if Yes, Give Year or Detes: 14. Race - American Indien, 11. Merital Stetus Bleck, White, etc. 1X Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 14 Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) William Ernest McCaffrey Bessie May Schaeffer 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 412 Baldwin Park Dr. Apart. B-1, Westminster MD 21157 Richard McCaffrey/nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2/23/98 4 ☐ Donation 5 ☐ Other (Specify) Kriders Cemetery Westminster, MD 22. Name end Address of Facility 91 Willis Street 21. Signature of unerel Service Licensee Myers Funeral Home Westminster, MD 21157 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Deet Immediate Cause (Finei Massove disease or condition resulting in death) Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as e consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chronic A.Fib., Bilateral Pleurel Esturium 24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth? 24a. Was en eutopsy Trocus purch Motral Regungo tentur 200 NO 1 Yes 28 No 1 TYes 25. Was cese referred to medical 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) populient 1 Yes 200 No 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28d. Describe how Injury occurred Naturei 2 Accident 5 Pending

law requires that the death certificate be executed physician end the burial-trensit Records, P.O. Box 68760. signed by the is certificate has director, page 2 Division of Vital

Examiner Physician/Medical by Completed Be Certification: To

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Directo

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3 Sulcide 4 Homicide 29a. Certifier

29b. Signature and title of certifier

6 Could pet be ertifying Physic Medical Examine

investigation

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o the best of my knowledg at the time, date end piace, and due to the ceuse(s) end manner as atated.

Stion, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s)

Injury at Work 1 es 2 No

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28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29c. License number

29d. Dete signed (Month, Day, Year) Pab lut laas

30. Name and address of gention who complet

31. Dete filed (Month, Dey, Year) FEB 2 0 1998 to tres Eldershy

Registrar

Medical

9804103878 UNIT # 20-40-61 MCCAFFREY, MARY HENRIETTA 151-B BOGDASCHEWSKYI, ALEX/II 01/03/1913 F 02/11/98 INP

98-0686-033 AM CURTIS NICHOLSON JR

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State of Maryland / Department of Health and Mental Hygiene

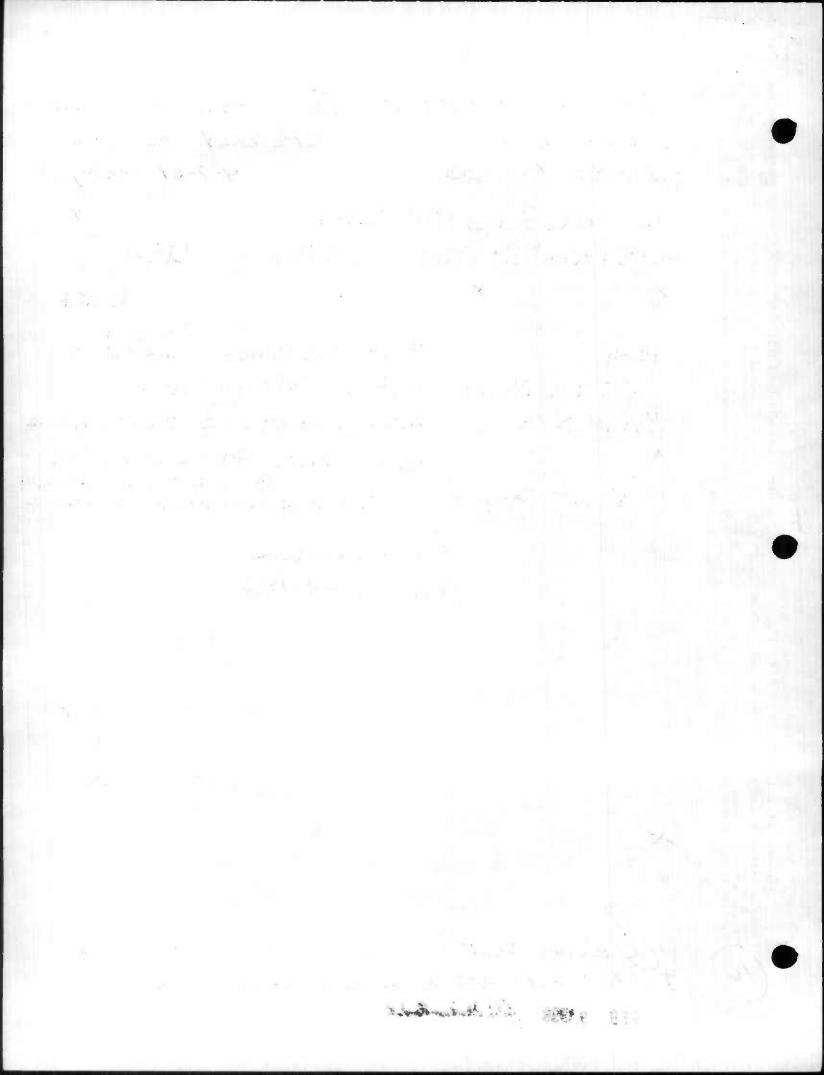
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Certificate	or Death

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/Medical Examiner	4a Facility Name (If not institution, giv				4b. City, Town, or L			y of Death	
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il -	5. Social Security Number 6. S	ex 7. Age (In yr		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B		. Country)	e (State or Foreign
tor	Usual Residence of Decedent	50				7-9	-61	WASH	1.1 D.C.
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Funeral Director	MID. HINCE	GEORGES ?	DUITI	-anc	λ				1 Yes 2 □ No
Dire	10e. Street and Number	t. U.Do		10f. Zip Code	7111		10g. Citizen of	What Country	7
eral	11. Maritel Status	12 Was Decedent Ever in	US 13 W	s Decedent of	Hispanic Origin? (Si	pecify Yes or N	0- 14. Ra	ca - Americen	Indien.
Fun	1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No			Hispanic Origin? (Sp pan, Mexican, Puerto	Rican, etc.)		ack, White, etc	. 1/
1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	11	Yes 2 No	Specify:		Speci	2. PIC	ick
Be Completed	15. Decedent's Ed (Specify only highest gra	ducation de com <i>pleted)</i>	16a. Decedar (Give kir	nt's Usual Occu	pation during most of work ed)	king	16b. Kind of E	Businass/Indus	try
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Ö	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middl			
ToB	COSTER	Nichols	SONS	SR.	Vivi	AN)	Wall		
	19a. Informant's Name/Relationship			Address (Stree	t and Number or Ru	ral Route Num	ber, City or Town	, State, Zip Co	ode)
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	1 Buriel 2 □ Cremetion 3 □	Removal from State	cemetery, crema	tory or other pla	A O A A	a lia lac	land	01/00	MI).
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any injury or other treument event, the language. To Be Compi	Manay	Blunct	_	470	11617	h. H	LINKY	Tonera	1 Chape
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)	30. Name and address of person who	complated cause of death (It	em 23a) (Type, Pr	int)	OCME		FEBRUAF	(1 13, 1	990
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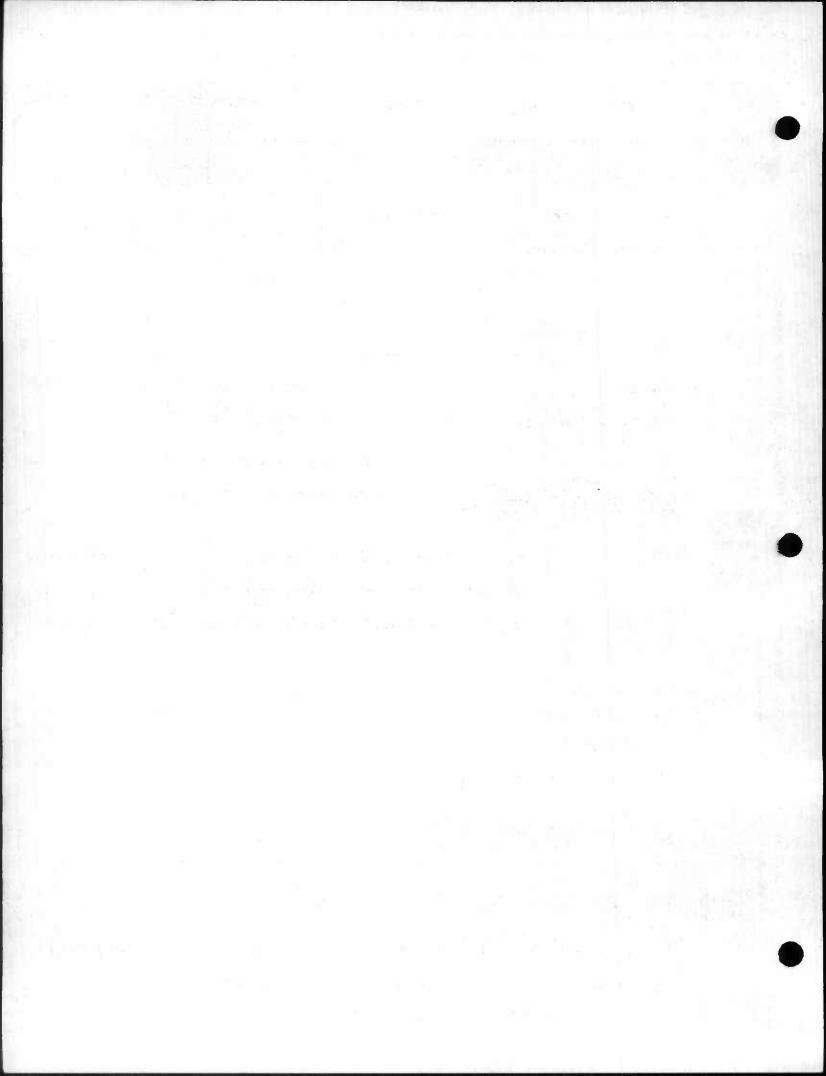
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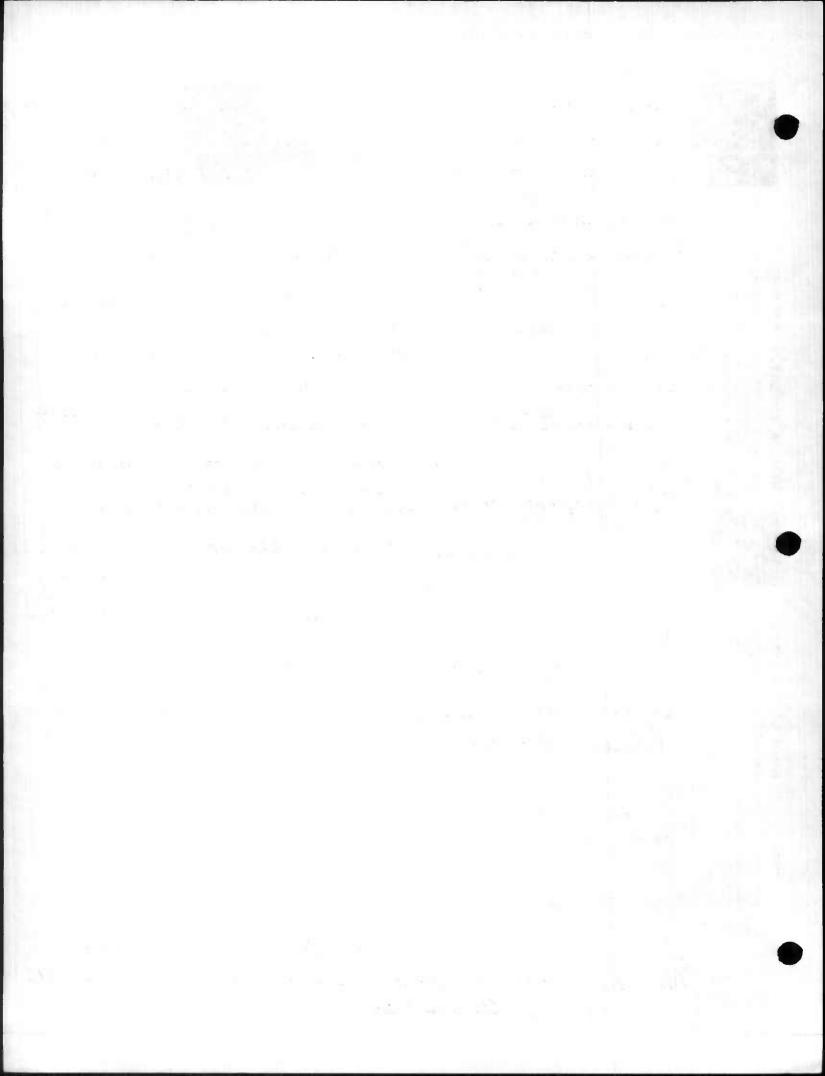
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	/Medi	cal	ANNA	MAE	ODE.	00	4b. City, Town, or I				0020	
	Examir	ner	4a. Fecility Neme (If not Institution, give Calvert Memorial				rince Fre		4c. County o			
	Funeral Director		5. Sociel Security Number 6. Se 214 86 4557	-	s. lest birthday; Yrs.	T	If Under 24 Hrs.				eca (State or Foreign ry)	
	Maryland -f show	tor	Usuel Residence of Decedent 10e. Steta 10b. County MD Calvert		City, Town or Lo					10	Od. Inside City Limits 1 X Yes 2 □ No	
	h with the	Funeral Director	10e. Street end Number 8930 Frederick A	ve.		10f. Zip Code 207	14	11	og. Citizen of Wi USA	het Coun	Country?	
020	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Haalth and Mantal Hyglene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	by	11. Marital Status 1 □ Navar Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Wes Decadant Evar in Armed Forces? 1 ☐ Yas 2€XNo If Yes, Give Yaar or Dates:		Was Decedent of if Yes, specify Cult	Hispenic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		, White, a	an Indian, atc. white	
21215-0020	2 should be filed within 72 hc and Manial Hyglene. Is marked other than "natur surmatic event, the Wedlea	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usuei Occu s kind of work done DO NOT use retin	during most of wor	king		n home		
	Hyg ent.	Be C	17. Father's Name (First, Middle, Last)		1100	Dewille	18. Mothar's Nan	na (First, Middle, A	ddle, Malden Surname)			
lar	Antal ked or tic eve	To B	Joseph	C	haney		Emily	Grace	Chane	еy		
, Maryland	s 1 and 2 should if Haalth and Man Item 27 is marke other traumatic		19e. Informent's Name/Relationship (7) Linda S. Dillon/da				North Bea		City or Town, S 20714	itete, Zip	Code)	
Baltimore,	permit. Pages 1 and Department of Haalth Important: if Item 27 eny Injury or other to once.		20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	temoval from Stata		osition (Neme of metory or other plants) nv UM Ch	urch Cem.		Owings			
Balti	permit. Pages Department of Findortant: if Ite eny Injury or of page.		21. Signature of Edneral Service Licens		2	2. Nama and Addr				207:		
	-		234. Peri 1. Enter the disease, or compi shock, or heert feilure. List only or	icetions that caused the de							Approximate Interval Between	
	Physician /Medicai			. Acute 1							Onset and Deeth	
	Examiner	-e	resulting in death)	Due to	(or es e conse	quence of):	Λ. Λ.	Hoole		12.	Munder Muntes	
	and -transit	Examiner	Sequentially list conditions,	Due to	(or es e conse	quence of):	7947 W	Janana	_	ľ	mutes	
Box 68760,	eath certificata be axecuted attending physician and I for use as the bunal-transit	ledicai	Sequentielly list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest		or es e consec		Curellor	oscular	Disea	12	yeurs	
	death e atte	sicia	Part II. Other eignificent conditions cor	ntributing to death but not re	sulting in the u	inderlying cause g	ause given in Part I. 23b. Did tobecco uee cont			tribute to the cause of deat		
s, P.O	requires that the death cert seen signed by the attendin hould be detached for use	by Physician/N	Part II. Other elgnificent conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Hyperliphdemia Renal Insufficiency						1 Yes 2 No 3 Probably			
Records,		Completed t	Hyperliptden	ita				24e. Was an perform		con	re eutopsy findings ilieble prior to appletion of cause leath?	
R	The law ate has page 2	mo	Renal Insu	fleteney				1 □ Ye	s 2 No		Yes 2□ No	
Vital		Be	25. Wes case referred to medical exeminer?				26. Piece of Dee	th (Check only on	e)			
£	Physician: r this certific ral director,	ပ္	1 ☐ Yes 2 No	Table 1	ER/Outpetie	III BLI DOA		ome 5 Reside)	
ion	ath. r: After ne funer	ation	27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigetion	28e. Dete of Injury (Month, Day Yeer)	28b. Time o Injury	We	iry et ork?]Yes 2□No	28d. Describe ho	w injury occurre	d		
Division	al or Atte s after de il Directo	Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At building, etc. (Spec	home, farm, st	reet, fectory, office	,	28f. Location (St. City or Town		r or Rure	Route Number,	
	To the Hospital or Attending Phymitin 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	elcien: To the best of my kiner: On the basis of examined mennar stated.	nowledge, deet nation end/or in	h occurred et the t vestigetion, in my	ime, dete end pleca opinion, deeth occu	, and due to the ce rred et the time, de	use(s) end men ete end plece, er	ner as sto nd due to	eted. the cause(s)	
	Withi To the	M	29b. Signature end title of certifier	0 04			sa number		d. Date signad	(Month, L	Dey, Year)	
			Gerald	P. Sterr	es m	D 1	117243	7	Feb	21	, 1998	
	15		30. Neme end eddress of person who co	mpleted cause of deeth (Ite	em 23e) (Type,							
	_	.	DR . GERALD P . S 31. Dete filed (Month, Day, Year)	STERNER, M.D. 32. Registrar's Sign		CE FREDI	ERICK, MD	20678				
	Sta Registr		FEB 24	1998 > Julia	Dhudson	Rardall						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

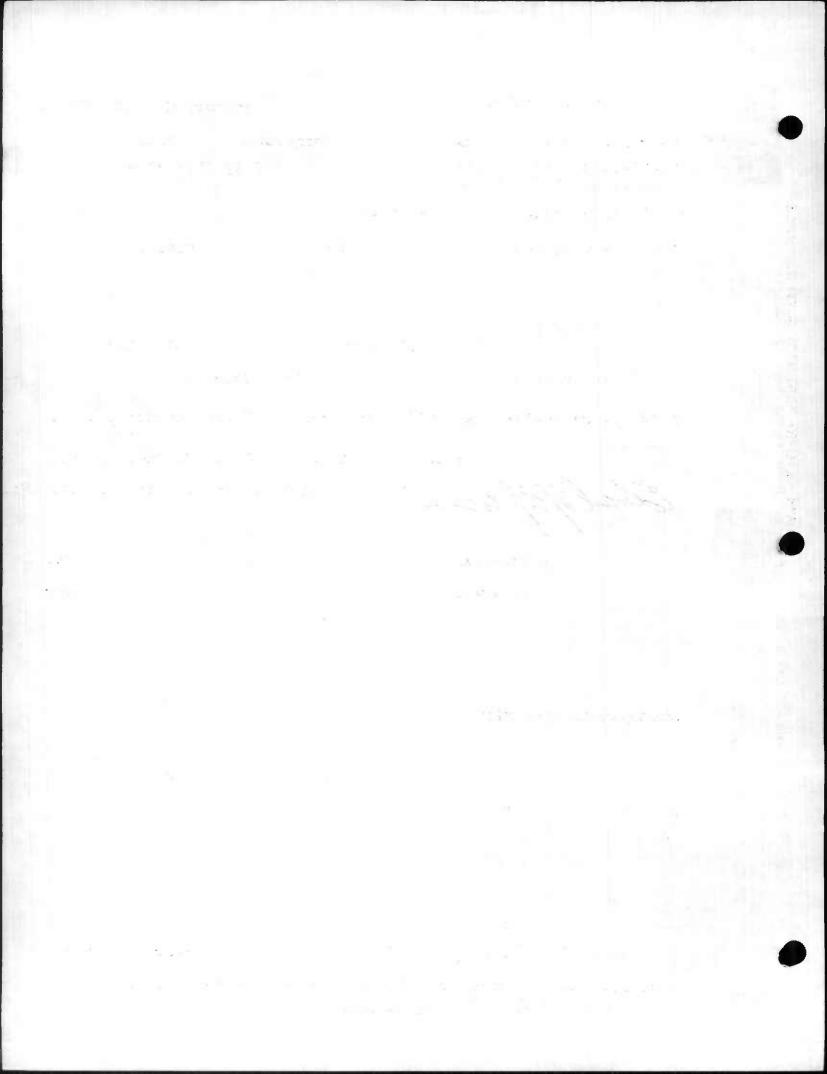
			Certificate				eg. No.9 8	0	/052
	Physici		1. Decedent's Nema (First, Middle, Last) Alexina Phillips		!	2. Dete of Dead Month F'CD. 2	h 20, ^{Dey} 199	Š ^{aer}	3. Time of Deeth 8:45 am
	/Medio Examin		4e. Fecility Neme (If not Institution, giva street and number)	4b.	. City, Town, or Lo	cation of Daeth	4c. County of	of Deeth	
			Mallard Bay Center		Cambri	dge	Do	rche	ester
	uneral irector		5. Sociel Security Number 212-16-7178 6. Sax 1 M 2 F 7. Age (In yrs. lest birthday) Months Months		If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Dey, Apr. 1,	Year) 1903	9. Birthpi Coun Ma	lece (Stete or Foreign try) ryland
yland	wow.		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					16	0d. Inside City Limits
Ø ⊠	E P	ctor	Maryland Dorchester Fish	ing	Creek				1 ☐ Yes 2X No
igh th	9 2 S	Director	10e. Street and Number 10f. Zip			1	0g. Citizen of W	ten of Whet Country?	
ath w	238		2524 Hoopers Island Rd.		634			S.A.	
5-0020 72 hours efter death with the Maryland	al', or items 23a or 28a-f show Examiner must be notified at	by Funeral	11. Maritel Stetus 1 □ Navar Married 2 □ Married 3 2 Note of Yes, Give Yeer or Detas: 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yas 2 Note of Yes, Give Yeer or Detas: 13. Was Decedent Yes in U,S. Armed Forces? 1 □ Yes, spec		penic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify:		
15-0	natural', ledical Exe	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usue (Give kind of wor	et Occupeti erk dona du	ion Iring most of worki	ing	16b. Kind of Bus		
21215-0020 d within 72 hours of gione.	the M	Completed	Etamantary/Secondary (0-12) Coilega (1-4or 5+) Crab Pi				Shel.	lfis	sh
Maryland 2 d 2 should be filed v th and Mental Hygie	0 0	To Be C	17. Father's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surneme)					
arylan should be	7 is marke traumatic		Wilbert Aaron	/C11		e Smit			0-40
Ma Ma Ma Man			19a. informant's Neme/Reletionship (Type, Print) Granddaughter Carol Ruark Jones 19b. Meiling Address 2833 Hoo						
re, N s 1 end f Health	- 0		20a. Method of Disposition 20b. Pieca of Disposition (Nem cemetery, crametory or of				20c. Location - 0		
Peges ent of	pamit. Peges 1 e Department of Hea Important: if Item any Injury or othe		1 Burial 2 Cremetion 3 Remove from State 4 Donetion 5 Other (Specify)		1	-24-98	Cambi	rido	e, MD
Balti permit. Departm			21. Signature of Funeral Sarute Licensee 22. Name and	nd Address	of Facility	Funera	1 Home	D	λ
			23a. Fifth Enter the disease of complications that caused the deeth. Do not antar the mode	igh S	St., Ca	mbridg	e, MD	2161	Approximate intervet Batween
	sician edical								Onsat and Deeth
	miner		disease or condition resulting in daeth)		y all			1	ours.
D D	ai.	Iner	Due to (or es a consequance of):					-	Jean.
68760, fficate be executed	physician and s the bunal-transit	i Examiner	Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Cause (Disease or injury		one	•)	noneñ
~ ~	C 0	edicai	resulting in deeth) Last Due to (or es e consequence of):	11.	-1. 0			ms	
	attending for use e	M/ut	La Upper al	bu	edu	73			77,700
0	the atte	sicia	Part II. Other significant conditions contributing to deeth but not resulting in the underlying or	ause given	n in Pert I.	23b. Did to	bacco uee conf	tributa to	the cause of death?
J. #	5 6	by Physician/N	Seuce Alzheimus			1 🗆 Y	2 2 NO.	3 🗆 Prob	bably 4 Unknown
Vital Records,	hes been signed to ge 2 should be det	Completed	Teluic Gradine			24a. Was e perform	n eutopsy ned?	cor	ara eutopsy findings eilabte prior to mpietion of cause daeth?
~ e	page	Con				1 □ Ye	s 200 No	1 🗆	Yes 211No
Vita clan:	certificate rector, pag	Be	25. Wes case referred to medical examiner?		26. Plece of Death	(Check only on	e)		
of Vita Physician:	this c	2	1 Yas 2 No. Hospitei: 1 Inpatiant 2 ER/Outpetient 3 DO		4 Dursing Ho	me 5 Reside			')
VISION Attending For death.	: After e funer	ation	27. Manner of Deeth 1/SNaturel 5 □ Pending 2 □ Accidant investigation 28a. Date of injury (Month, Day Year) 28b. Tima of Injury M	28c. injury e Work? 1 ☐ Ye	es 2 No	28d. Describe ho	ow injury occurre	ea .	
Division of all or Attending Physics after death.	if Director: After this co	Certification:	3 Suicide 4 Homloide 6 Could not be determined 28e. Pieca of Injury - At homa, farm, streat, factory building, etc. (Specify)	/, offica	4	28f. Location (St City or Town		or Aura	l Route Number,
To the Hospital o	To the Funeral Dirccompletely filled in	Medical	29a. Cartifier (Check only one) 1. Certifying Phystotan: To the basis of my knowladga, daath occurred a common of the basis of axamination end/or investigation, and manner steted.	at tha time, in my opir	, data end place, a nion, daath occurre	and dua to tha ca ed at tha tima, d	ausa(s) end men ata and piaca, ei	ner as st nd due to	eted. the ceusa(s)
o the	o the	Me	one marrier stetoe.	c. License r	number	2	9d. Data signad	(Month, I	Day, Year)
F 3	Þō		AND ARCHARD AND AND AND AND AND AND AND AND AND AN					-	
			30 Name end eddrass of person who completed cause of death (Item 23e) (Type, Print) Annual Nawaz 105 Annual	SW	ect C	amb	ridge	n	102/613
	Sta	te	31. Deta filed (Month, Day, Year) FFR 2 4 1998 32. Rysistrer's Signature FFR 2 4 1998						



State of Maryland / Department of Health and Mental Hygiene

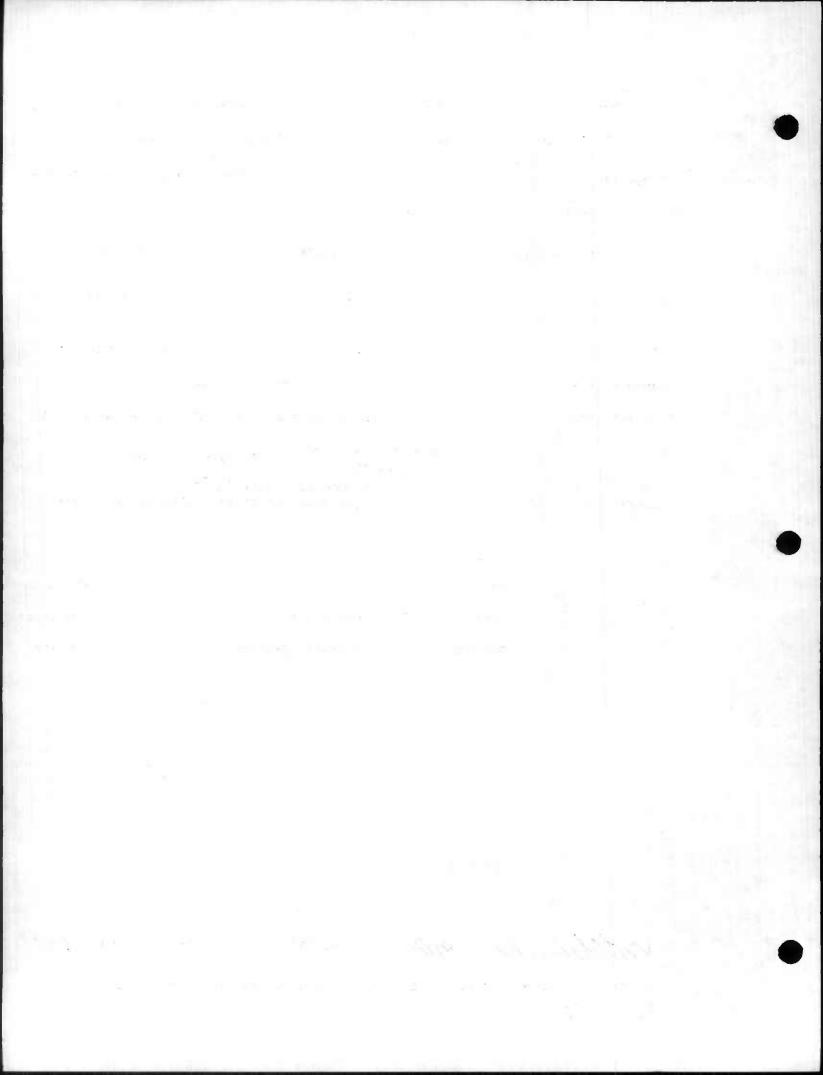
Physici /Medic	an I							2. Date of De			3. Time of [Main
71110011		Glenn J.	Peoples	Jr.				Februa	ry I3,	L998	09:3	MAO
Examin	-	4e. Facility Name (If not institution, gi						or Location of Deet				
		VA Maryland Healt 5. Social Security Number 6.				nday) If Under 1 Yes	Perry Po	oint rs. 8. Date of Bi	Ceci			
Funeral Director			Sex 7.7 1 1 M 2 □ F	Age (In yrs. Id 64		Months Day	/s Hours M	in. Ju My th, P	5 Yel/933	9. Birthp Coun On 1	place (Stete or htry) O	Foreign
pue *		Usual Residence of Decedent 10e. Stete 10b. County		10c City	Town	or Location				1	0d. Inside City	Limito
the Marylenc 7 28a-f show	ctor	W. Virginia Be	erkeley			nsBurg					1 Yes	
th with	ral Dire	10e. Street and Number 210 West Race	e Street				401		U.S.A	•		
after or ite	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces Marmed Forces Marmed Forces Marmed Forces Marmed Forces If Yes, Give Year or Dates	s?] No	S.	13. Was Decedent of If Yes, specify Control of It Yes 24240		(Specify Yes or No erto Ricen, etc.)	Bled	e - Americ k, White, Whi		
72 hours naturel',	etec	15. Decedent's E (Specify only highest gi			16a. l	Decedent's Usual Occ 'Give kind of work don life. DO NOT use ret	cupation ne during most of v	vorking	16b. Kind of Bu	isiness/Ind	dustry	
filed within Hygiene. ther then	Be Completed	Elementery/Secondary (0-12)	College (1-4o	or 5+)	1	Me. DONOTuse ret Disabled	ired)	Ü	Disa	oled		
e filed within sel Hygiene.	ပိ	17. Father's Name (First, Middle, Las	t)				18. Mother's N	leme (First, Middle	Meiden Sumen	e)		
ould be Mentel arked o	To Be	No Inform	nation				No	INforma	tion	ы		
2 sh end is m		19e. Informant's Name/Relationship (Type, Pnht) Glenda F. Mayes-Pers.Rep. 19b. Mailing Address (Street end Number or Rurel Route Nu 20222 Trovinger Mill La							e Hage	rsto	wn Md	
St 1 a of Her Kem		20a. Method of Disposition		20b. PI	ace of	Disposition (Name of c, cremetory or other p	olece)	Date	20c. Location -	City or To	own, Stete	
Page nent ant: If		1 ☐ Burial 2000 Premation 3 [4 ☐ Donation 5 ☐ Other (Speci		10		Ferris I		2-22-98	W. Che	ester Pa.		
permit. Pages 1 and Depertment of Heelth Important: If item 27 eny injury or other to once.		21. Signature of Funeral Service Lie	ensee	10-1		22. Name end Add		me 259	E. Main	n St	. Elk	tor
Physician		23a. Part1. Enter the disease, or for shock, or heart failure. List only	nplications that caus one cause on each	ed the death line.	. Do no	ot enter the mode of c	lying, such as cerd	liac or respiratory a	rrest,		Approximate Interval Betwo Onset end De	
/Medical Examiner	-	Immediate Cause (Final disease or condition resulting in death)	e. Uroser		es e c	onsequence of):				1	lwo_wee	ks
nsit	Examiner		b. Pneumo							1	Two wee	ks
rificete be axecuted ag physician and as the buriel-transit	cai Exa	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events	c			onsequence of):						
± 0 €	Cause (Disease of Injury that Initiated events resulting In death) Last Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Schizophrenia. Malnutrition 1 Yes 2 No 3 Prof											
the death y the etten sched for u	sicia	Part II. Other significant conditions	the underlying cause	given In Part I.	23b. Did	tobacco use cor	pacco use contributa to the cause of dea		death			
	by Phy	Schizophrenia,	Malnutrit	ion				10	Yes 2 XNo	3 Pro	bably 4□U	nknov
ne law requires that the death cer e has been signed by the ettendin tge 2 should be detached for usa	Completed b							24a. Was	performed? ava		ere autopsy fin allable prior to mpletion of ca death?	
	Sol							10	Yes 2X No	1[Yes 20 N	lo
ysicien: The law is certificate has t director, page 2 s	Be	25. Wes case referred to medical examiner?	Hospital: 32					eath (Check only	one)			
this alo	-T	1 Yes 2 No	28a. Date of In		ER/Outp 28b. Ti	Datient 3LJ DOA		Home 5 Res	dence 6 Oth		y)	
lending Ph leath. or: After thi tha funaral	tion	1 XNatural 5 Pending 2 Accident Investigation	(Month, E	Dey Year)		ury V	Vork? ☐ Yes 2 ☐ No	200. Describe	now injury occur	80		
f or Attending I effer death. Director: Affer d in by the fune	Certification:	3 Suicide 6 Could not be determined	n, street, factory, offic				er or Rura	al Route Numb	er,			
Hospi Hospi 24 hou Funer taly fill	Medicai C	29a. Certifier (Check only one) 1 ☑ Certifying Pl	hysician: To the bes miner: On the basis and menner:	of examinati	rledge, on and	death occurred et the or investigation, In m	time, date and pla y opinion, death oc	ce, and due to the curred at the time,	cause(s) and me date and place,	nner as s	tated. the ceuse(s)	
within 70 the To the comple	Me	29b. Signeture end title of certifier	19			29c. Lice	nse number	T	29d. Dete signe	d (Month,	Dey, Year)	
E > E 0		1 de 1	· No	/	W	UP D166	O8		Fohman	., 12	1009	
		30. Name and eddress of person who	completed ceuse of	death (item	0	DIOC	000		Februar	у 13	, 1330	
	30. Name and eddress of person who completed cause of death (item 23e) (Type, Print) KAM KEN LEUNG, M.D., VA Maryland Health Care System, Perry Point, MD											
		KAM KEN LEUNG, M.	D. , VA Mai	ryland	He	alth Care	System,	Perry Po	int, MD	2190	02 -	

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate o	f Death	1	Reg. No. 9 8	0.	7054	
	Physici	ian	Decedent's Name (First, Middle, La	st)					2. Date of Dea Month	by 15, 1	Year	3. Time of Death	
	/Medi		Margaret		Palm	er		# 07 T				1130 A	1
	Examir	ner	4a. Facility Name (If not institution, give		o Con	ton			Location of Death				
	-		MedPointe Cont: 5. Social Security Number 6.3			ast birthday)	If Under 1 Yea	Elkt ar If Under 24 Hrs		Cecil		Inna (Canto on Form	
	Funeral Director			1 M 2 M F	83	Yrs.	Months Day					lace (Stete or Forei try) nsylvania	
	and **		10e. State 10b. County		10c. Clty	, Town or Lo	cation				1	0d. inside City Limi	its
	with the Maryland a or 28a-f show	ctor	Maryland Kent		G	alena						1 ☐ Yes 2 🛣 N	
	or 28	Dire	10e. Street and Number				10f. Zip Code		1	10g. Citizen of W	/hat Coun	itry?	
	€ 23	La	107 West Cro					1635				tates	
020	or ite	by Funeral Director	11. Maritel Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces? 1 ☐ Yes 2 II If Yes, Give Yeer or Dates:			Vas Decedent of Yes, specify Cu	Hispenic Orlgin? (S ben, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	No- 14. Rece - American Indian, Black, White, etc. Specify: White			
21215-0020	72 nat	Completed	15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12)	ducation ide completed) College (1-4or 5	i+)	(Give I life. D	ent's Usuei Occ kind of work don DO NOT use reti	Usuel Occupation If work done during most of working Thuse retired) Allied Chemi					
d 2	Hygid ther ther	S	17. Father's Name (First, Middle, Last)			TELK	18. Mother's Na	me (First, Middle,			BIIITCAT	-
lan	lid be lental ked o	To Be	James W. Walsh						M. Mose				
Maryland	d 2 should be filed within th end Mental Hygiena. 7 is marked other than traumatic event, it e Me	-	19a. Informant's Name/Relationship		et and Number or R					Ī			
	Heall nem 2		20e. Method of Disposition		20b. PI	ace of Dispos	sition (Name of		Date				
Baltimore,	Peges tment of tant: If H jury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			aculat V Ceme	e Heart	of of	2/19/98	20c. Location - City or Town, Stete Linwood, PA			
Balt	permit. Peges 1 end 2 should b Department of Health end Mente Important: If item 27 is marked any injury or other treumetic e once.		21. Signature of Funeral Service Lice	Hichs	/	Hi	Name and Add	e for Fur					
	_		23a. Pert1. Enter the disease, or com	plications that caused	the deeth	. Do not ente	3 West or the mode of d	Stockton ying, such as cardia	Street, ic or respiratory ari	Elkton,	MD	21921 Approximate Interval Between	-
d	Physician (Madical		shock, or heert failure. List only	one cause on each lii	ie.							Onset end Death	
	/Medical Examiner		Immediate Cause (Finei disease or condition resulting in death)	e. COPD	Due to /or	00.0.000000	uence of):					10 year	S
	sit 9d	iner		CAD	b						1	10 year	S
0,	an end unel-tran	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or as a consequence of): Many years of tobacco abuse 50						50 yea	ırs	
68760,	death certificate be executed e attending physician end of for use es the buriel-transit	edical	cause (Disease or Injury that initiated events resulting in death) Lest	c. Pneur	Due to (or as e consequence of): Pneumonia with respiratory failure						4 weeks	5	
Вох	aath cert attending for use	M		d									
	death e atte	Sicia	Part II. Other algnificant conditions of	ontributing to death b	ut not resu	Iting In the un	deriving cause	niven In Part I	23b. Did tobacco use contribute to the			the cause of deat	th?
P.0	es that the dai igned by the a be detached f	/ Physician/N		ontributing to death but not resulting In the underlying cause given In Part I.					1 X Yes 2 No 3 P				
Records,	been s	Completed by							24a. Was a	an autopsy med?	ava	ere autopsy findings aliable prior to mpletion of cause death?	s
R	The law ate has pega 2	E O							1□ Y	es 20 No	10	Yes 2□ No	
Vital		Be C	25. Was case referred to medical					26. Place of De	ath (Check only or	ne)			
of V	Physician: this cartific ral director,	To	examiner? 1 ☐ Yes 2 🔀 No	Hospitel: 1 Inpatie	nt 2 E	R/Outpatient	3□ DOA	Other: 4 Nursing I	Home 5 ☐ Resid	ence 6 □Othe	er (Specify	v)	
	g ag		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injui (Month, Day	Y Year)	28b. Time of Injury	28c. In W		28d. Describe h				
Division	To the Hospital or Attanding Phwitin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined		ry - At hor (Specify)	me, farm, stre	et, factory, offic	е	28f. Location (S City or Tow		er or Rura	l Route Number,	
	Hospi 24 hou Funer letely fill	edicai	29a. Certifier (Check only one) 1	ysician: To the best of niner: On the basis of and manner sta	exemineti	rledge, death on and/or inv	occurred et the estigation, in my	time, dete and place opinion, death occi	e, and due to the curred et the time, o	euse(s) end mai late and place, a	nner as st and due to	ated. the cause(s)	
	Fo the Within Fo the	Me	29b. Signeture end title of certifigr 29c. License number 29d. Date signed (Month,									Day, Year)	
	->-0		Moles	reham	m	D.		35779		Februar	y /s	1998	7
	10		30. Neme and address of person who	completed cause of de	eath (Item	23a) (Type, F	Print)						
			W. Bruce Ober	ohemia	Avenue, C	Cecilton,	MD 21	913					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland' / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Illiam Sam ما /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Street 90 Worcester DNO OCOMOKE If Under 24 Hrs. B If Under 1 Year 5. Social Security Number 6. Sex 12 M 2□ F 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Yrs. Director nit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland darment of health and Mental Hygiene. ordant: if terms 21 a marked other than "natural", or items 23 or 28a-1 show injury or other transactic event, as lactical Examiner mail to notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Worces 1XYes 2□No Ocomok 10e, Street and Number 10g. Citizen of Whet Country? 90 tree Reca - American Indian, Bleck, White, etc. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritei Status tores 2 No 1948 fYes 2 No 1948 fYes, Give Yeer or Dates: 1967 1 Never Married 2 Married 1 ☐ Yes 2 (No Baltimore, Maryland 21215-0020 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-2) College (1-4or 5+) Militar ENlisted Hrmed 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be UNKNOWN Lo 0 lander UNKNOWN 19e. informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ervin - SON OKe City Md, 2/85/ 20c. Location - City or Town, State OcomoKe 20a. Method of Disposition Date 1 ☐ Buriel 2 【Cremation 3 ☐ Removal from Stete Church Center 2/18/98 Poconoko, nd.
end Address of Fecility Bennic Smith F. Ho Department o important: if any injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Funeral Service Licensee 23a. Pet1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ship is repertable. **Physician** /Medical Immediate Couse (Finel disease or condition resulting in deeth) Examiner Physician/Medical Examiner tiple strokes or Attending Physician: The law requires that the death certificate be executed be detached for use as the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest pue Box 68760, Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 □ Probably ★ Unknown Completed by 24b. Were eutopsy findings evelleble prior to completion of cause of death? page 2 should 24e. Wes an eutopsy performed? this certificate 1 Yes 1 ☐ Yes 2 No director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home Residence 6 Other (Specify)
Injury et 28d. Describe how injury occurred 217 No Medical Certification: To 1 Yes To the Hospital or Attending Physi within 24 hours after death.

To the Funerel Director: After this c completely filled in by the funeral dir 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? **S**aturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner steted.

29c. License number

Street

cause of death (Item 23a) (Type, Print)

Luka Savidson-Randalle

32. Registrar's Signeture

edar

taubbs

29d. Dete signed (Month, Dey, Year)

Pocomoke, md.

Registrar **DHMH 16 Rev 6/95**

L'ANTIS

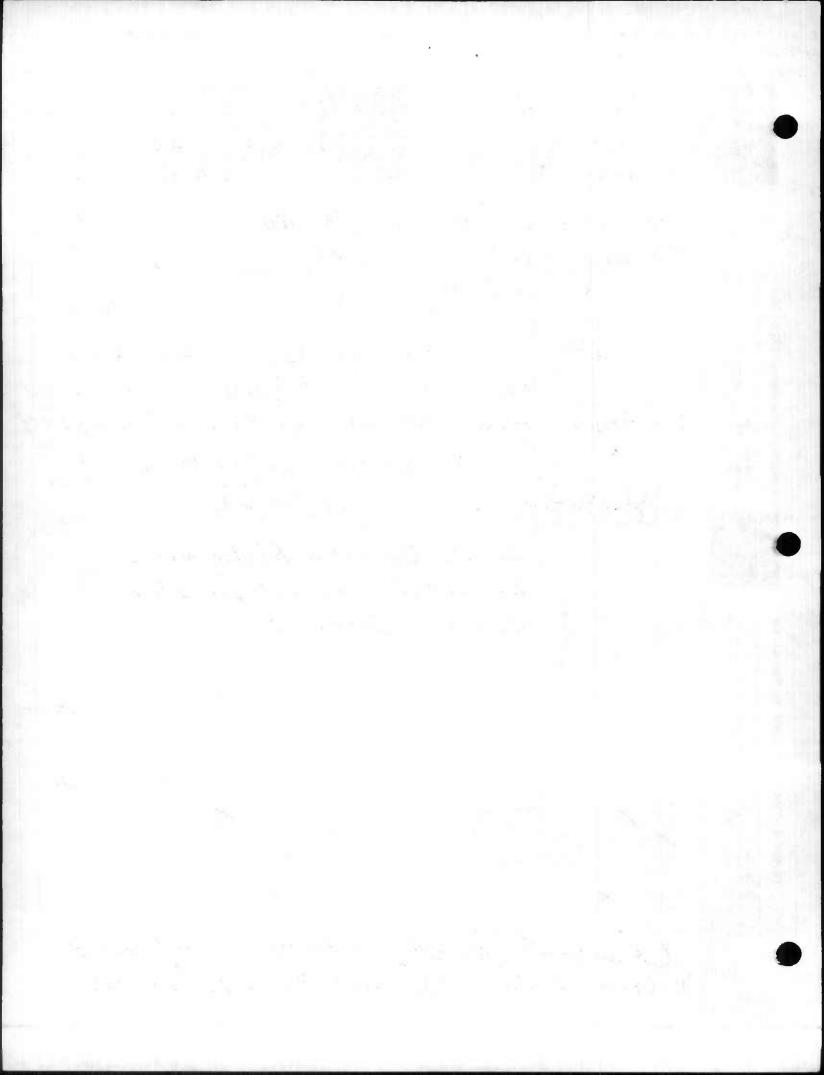
State

30. Name and eddress of person who

FEB 1 7 1998

Charles

31. Dete filed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Bea No. 9 8

							Cer	tificate o	f Death		Reg. No.	U	1006
			1. Decedent's Neme (First, Middle,	Last)						2. Dete of De	eth	19100	3. Time of Deeth
	Physic		Belin	nda Mic	helle	Hall	Lum	Richar	dson	Month Februa	ry 8, 19	Year QQR	6:20 P.M.
3	/Medi Examii		4a. Fecility Neme (If not institution, g	rive street and n	umber)				4b. City, Town, or				
7	Exami	iei	University of Ma			al Car	ter			re City	1000	n/a	
н	Francis			. Sex		yrs. lest birt		If U r 1 Y					inlane (State or Foreign
10	Funeral Director		578-72-1193 Usuel Residence of Decedent	1□ M 2Ã F			Yrs.	Months Dey		Januar	th Year) 955 y 22,		plece (Stete or Foreign intry) Worth, Texas
	Mand Mand		10a. Stete 10b. County		100	c. City, Towr	or Loc	cation					10d. Inside City Limits
	72 hours after death with the Maryland natural; or items 23a or 28s-f show picel Examiner must be notified at	Director	Maryland Montgo	omery		Ta	akon	a Park					Y Yes 2□No
	E 6 8	급	10e. Street end Number					10f. Zip Code			10g. Citizen of	What Cou	ntry?
	ath 233	ra	7800 Lockney						20912		United		
	ar de	Funeral	11. Maritel Status	Armed F		in U,S.	13. W	Yes, specify Cu	f Hispenic Origin? (S Joan, Mexican, Puert	pecify Yes or No o Rican, etc.)	b- 14. He	ce - Ameri ck, White,	fcan Indien, , etc.
21215-0020	n 72 hours aft natural', or	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	If Yes, G Yeer or			1	□Yes ¾∏XN	o Specify:		Specil	y: B1	ack
5-0	72 h	ted	15. Decedent's (Specify only highest of	Education	0	16e.	Deced	ent's Usual Occ	upation e during most of wor	kina	16b. Kind of B	lusiness/Ir	ndustry
121		Completed	Elementery/Secondary (0-12)		(1-4or 5+)		life. D	O NOT use reti	red)	King			
2	hygie v		4	6 year	:s	E]	Leme	ntary S	chool Tea				Schools
no n	should be filed within and Mentel Hygiena. marked other than imatic event, the M	Be	17. Fether's Neme (First, Middle, La	st)					18. Mother's Ner	ne (First, Middle	, Malden Surner	ne)	
× 3	Men	To	Bertrel1	Leonar	d	Hallu	ım		Delma	Rut	h Let	wis	
Maryland	C 0 0 0		19e. Informent's Name/Reletionship					-	et end Number or Ru				
	os 1 and 2 of Haaith item 27 i		Delma R. Hallur	n (mothe					Avenue, T	akoma P	ark, Mar	rylan	d 20912
ore	iges 1 if of He if item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3	□ Romoval from	1	Ob. Piece of cemeter	Dispos y, crem	sition (Neme of etory or other p	(ece) Feb. 1	4.1998	20c. Location	- City or T	own, Stete
Ë	Pag nent nnt: I		4 Donetion 5 Other (Spec						ial Park	,,,,,,,	Arling	ton.	Texas
Baltimore,	permit. Pages Department of Himportant: If Its eny injury or of 2009.		21. Signeture of Funerel Service Lin	ensee			22.	Neme end Add		rrow &			c. Funeral
0	88 E 5 8		12 A	20				nome					
			23e. Pert1. Enter the diseese or co	mplicetions that	caused the	deeth. Do n	ot ente	r the mode of d	th Street	or respiretory e	ashingto errest.	on, D.	C. 20001 Approximete
	Dhuciaian		shock, or heert feilure. List on	ly one ceuse on	eech line.				,				Intervel Between Onset end Death
	Physician /Medical		Immediate Cause (Final		Dunt	urod ('oro	bral An	0117617.000				2 1000
1	Examiner		disease or condition resulting in deeth)	θ					reurysm				3 days
		ē			Due	to (or es e d	consequ	uence of):				i	
	petr	퉅		b				,				i	
,	ertificate be axecuted ding physician and se as the burial-transit	Examiner	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury		Due	to (or es e c	onsequ	ience of):				1	
68760,	sicial burn		Cause (Disease or Injury thet initiated events	c			Gu z E so						
.89	tificati g phy as the	Medical	resulting in deeth) Lest		Due	to (or es e c	onsequ	ience or):					
×	eath certif attending for use a	2		d									
Bo	atte for	Physician											
o	the de	1ys	Pert II. Other algnificant conditions	contributing to	death but no	t resulting in	the un	deflying cause (given in Pert I.				to the cause of death?
<u>α</u>	that ed b									10	Yes 2 □ No	3 ∐ Pro	obably XX Unknown
Records,	200	d by								240 14/00	en eutopsy	24b W	Vere eutopsy findings
Ö	v require been si should I	Completed									ormed?	9/	veileble prior to ompletion of cause
še	SON	ldu										of	f death?
N F		S								1 🗆	Yes 2X No	1	☐ Yes 2☐ No
Vital	Physicien: The this certificate ral director, pag	Be	25. Wes cese referred to medical examiner?						26. Plece of Dec	eth (Check only	one)		
of	hysic lis ca li dire	To	1 ☐ Yes 2 No	Hospitel: 1X	Inpatient	2 ER/Out	tpetient	3□ DOA C	Other: 4 Nursing H	lome 5 Resi	dence 6 DOt	ner (Speci	ify)
n	aling Ph h. Aftar th funaral	:uc	27. Manner of Deeth 1 ☑ Neturel 5 ☐ Pending	28e. Dete (Mo.	e of Injury onth, Day Yea		ime of	28c. Inj	ury et ork?	28d. Describe	how Injury occu	rred	
0	Attending ir deeth. ector: Aftar by tha funa	atio	2 ☐ Accident investiget						☐ Yes 2☐ No				
Division	i or Attendi after deeth Director: A d in by tha f	Certification:	3 Suicide 6 Could not 4 Homicide determine	200. Piec	e of Injury - ding, etc. (S)		rm, stre	et, factory, offic	ө	28f. Location (City or To		ber or Run	rel Route Number,
	ad in	Ce				,,					,,		
	To the Hospital or / within 24 hours aftar To the Funeral Directon pletely filled in the	edical	29a. Certifier 157 Certifying I Medicai Ex	aminer: On the I	e best of my basis of examener steted.	knowledge, minetion end	, death i/or inve	occurred et the estigation, in my	time, dete end plece opinion, deeth occu	, and due to the rred et the time,	ceuse(s) and m dete end plece,	enner es s end due t	stated. to the ceuse(s)
	To the I within 2 To the I complet	₩.	29b. Signeture end will of certifier					29c. Lice	nse number		29d. Date signe	ed (Month,	, Day, Year)
	F S F O) < /					b	10252		Fohmer	2007 1	16 1000
			- W	2		4	_			Marral			16, 1998
			30. Neme end eddress of person who	o completed cau					reet, Bal				
	Sta	te	31. Dete filed (Month, Dey, Year)	32	Begistrer's S	Signature					J		
	Registr		FEB 17 19		hi she	deorba	del						
		_											

The state of the s

		Decedent's Neme (First, Middle, Last)			rtificate of	Death		Reg. No.	3 0	/057
Physiciar /Medica	_	CHRISTINE FINCHER ROGE	RS				2. Dete of D Month Februa:	Dey	1998	3. Time of Death 02:42 a.m
Examine	- 1	4e. Facility Neme (If not institution, give street end number ST. MARY'S COUNTY HOSPIT				4b. City, Town, or L LEONARD			y of Deeth	
Funeral		5. Sociel Security Number 6. Sex 7. A		last birthday)	if Under 1 Yeer Months Days		8. Dete of B	irth	ARY S	ece (Stete or Foreign try)
Director		246-12-6702 1□ M 2 X F Usuel Residence of Decedent		72 Yrs.	Working Days	Tiodis Will.			DURHA	M, N.C.
should be filed within 72 hours effer death with the Meryland nd Mentel Hygiene. Transfed other than "natural," or items 23a or 28a-f show urratic event, the Medical Evantines rount be notified at To Re-Completed by Finneral Director		10e. Stete 10b. County	10c. City	y, Town or Lo	ocation				10	Od. inside City Limits
vith the Me	ecto	MARYLAND ST. MARY'S	LE	XINGTO	N PARK					1 Yes 2 No
With a		10e. Street end Number 47247 SILVER DR.			10f. Zip Code 206.	52		10g. Citizen of		
r items 23s	nera	11. Meritai Status 12. Wes Deceden	t Ever in U,	S. 13. \		dispenic Origin? (Spen, Mexican, Puerto	pecify Yes or N	O- 14. Ra	ca - America	an Indien,
at, or it	by ru	1 Never Merried 2 Married 1 Yes 2 Married 3 Widowed 4 Divorced Year or Detes			1 ☐ Yes 2 X No	Specify:	rican, etc.)		ock, White, e	
natura pical i	Dele	15. Decedent's Education (Specify only highest grede completed)		16e. Deced	dent's Usuei Occup	petion during most of world	cina .	16b. Kind of E	Business/Ind	ustry
hygiene. her than "naturn nt, the Medical	duo	Elementery/Secondery (0-12) College (1-4or	5+)	HO	USEW1FE	d)	w.y	DOMES	TIC	
Department of neeting and washed other than "natural", or items 23a or 28e-f show any Injury or other traumatic event, the Medical Examinet must be notified at once. TO Re Completed by Financial Director	ů	17. Fether's Name (First, Middle, Last) JOE FINCHER				18. Mother's Nam	e (First, Middle		me)	
th and N 7 Is mar traumat		19e. Informent's Neme/Relationship (Type, Print) MIRANDA ROGERS / DAUGHT:	ER			end Number or Ru	ral Route Numb	per, City or Town		
ten 2 other	-	20e. Method of Disposition	20b. P	lace of Dispo	sition (Neme of		Date	20c. Location		Mn, Stete
ary or		1 X Buriei 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)	3		R NATIONA	AL CEM. 2	/17/98	CULPEP	PER.	VA _
epartr nportu ny Inj		21. Signature of Funerel Service Licensee		22	. Name end Addre					
		23a. Pert1. Enter the disease, or complications that cause shock, or hearf fellure. List only one ceuse on each			5538 MAR	LBORO PIR	E/FORE	STVILLE,	MARY	LAND 20747
lew requires that the deeth certificate be executed as been signed by the ettending physician and a should be deteched for use as the buriel-transit pleted by Physician/Medical Examines	Calcal	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest		es e conseques es e consequ						
ettend I for us	100									
been signed by the ettending should be deteched for use a stood by Physician/M		Pert II. Other significant conditions contributing to deeth I				en in Pert i.		tobacco uss co Yes 2□ No	3 Prob	the cause of death? ably 4/1 Unknown
page 2 should by							24a. Wes	s an autopsy ormed?	con	re autopsy findings ilebie prior to apletion of cause eath?
page page							10	Yes 20 No	1 🗆	Yes 2 No
rector Be	3	25. Wes case referred to medical Hospitei: Hospitei:			Oth	26. Piece of Deet				
After this c funeral dire		7 Manner of Deeth 28a. Dete of Inju	ıry	ER/Outpetien 28b. Time of	28c. Injur	4 LI Nursing Ho		idence 6 □Oth how injury occur)
		Naturei 5 Pending (Month, De investigation	y Year)	injury		k? Yes 2 □ No				
al Director: After to de In by the funeral Certification:		3 Suicide 6 Could not be determined 28e. Place of in building, et	jury - At hor tc. <i>(Specify</i>)	me, farm, stre	eet, factory, office		28f. Location (City or To	(Street end Numi wn. Stete)	ber or Rural	Route Number,
Funer Funer tely fill		29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Madical Examiner: On the basis of end menner st	f examineti	riedge, deeth on end/or inv	occurred et the tin estigetion, in my o	ne, dete end piece, pinion, deeth occur	end due to the red et the time,	ceuse(s) end m dete end plece,	enner es ste and due to	eted. the cause(s)
To the		9b. Signature and the of certifier		^	29c. Licens	e number		29d. Dete signe	ed (Month, D	Pey, Year)
2)	-	· Myon to	mi)	1) (1582		2-1	11-7	8
5/		0. Name and eddress of person who completed cause of a Sox of Sox	deeth (item	23e) (Type, F	rochoun /	MA aplas	50			
State		11. Dete filed (Month, Dey, Year) 32. Pegish	ray's Signati	are P. J.	al .					

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State of Maryland / Department of Health and Mental Hygiene

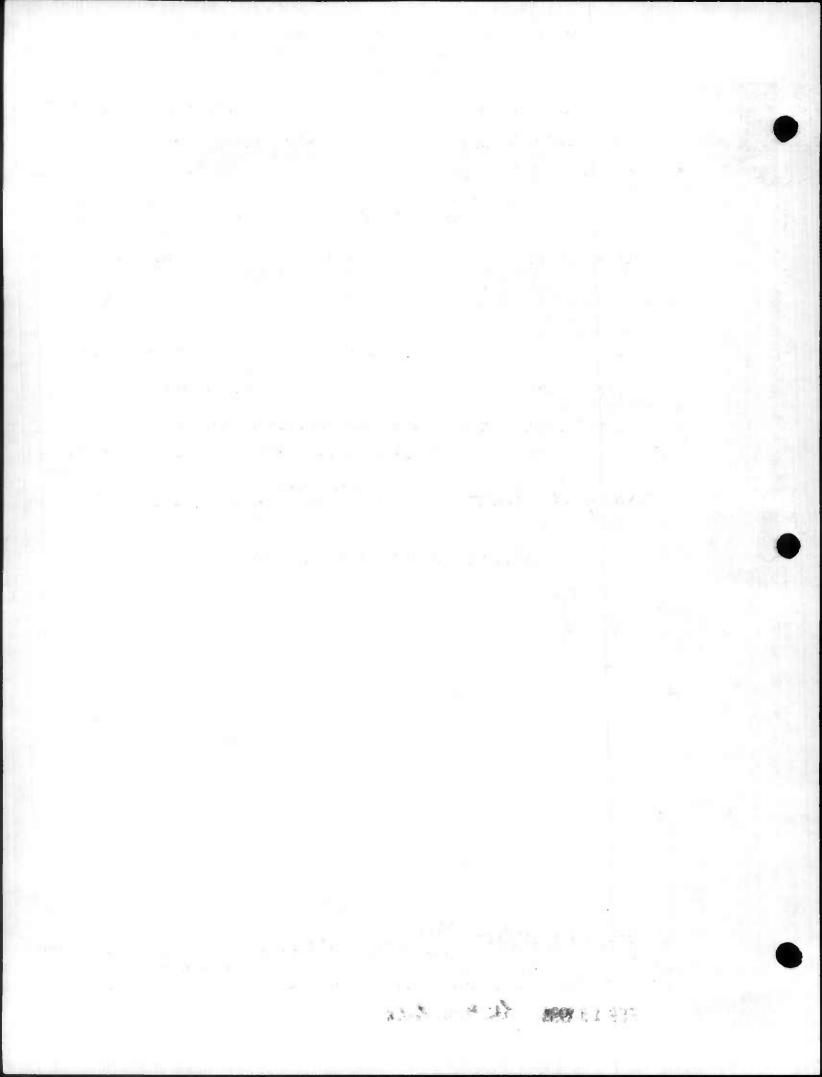
					Certific	cate of	Death		Reg. No.	U U	1058
Physicia	an	1. Decedent's Nema (First, Middle, Las	(1)	0				2. Data of De Month	eath Day	Yaar	3. Tima of Death
/Medic		KOBERT	4	KAF	F,	Jr.		FEBRU		1998	11:45A
Examin	-	4a. Facility Neme (If not institution, give	street end number)				4b. City, Town, or			nty of Deeth	
		Washington Advent					Takoma P			tgome	ry
Funeral	H	5. Social Security Number 6. Si	ax 7. Aga (⊠M 2□ F	In yrs. last bir	Mor	Indar 1 Yaar	If Under 24 Hrs Hours Min		th ay, Year)	9. Birthp	place (State or Foreign
Director		578-54-8707 Usual Rasidence of Decedant	**	56	Yrs.			April 8	, 1941	Wasi	hington, DO
ž		10a. Stata 10b. County	1	0c. City, Town	n or Location	1				1	I Od. Inside City Limits
ms 23a or 28a-f show crivant be notified at	ō	Maryland Prince			svill					Ι.	1 X Yas 2 No
a or 28a-f show be notified at	Funeral Director	10e. Street end Number	353185 3	ny acc.		f. Zip Coda			10g. Citizen o	4 Miles Cour	
0 80	ā	6724 Stanton Road			10				-		itry?
read l	era	11. Marital Status	12. Was Decedent Eva	r in II S	12 Was F	20784		Pagaih: Vag or N	U.S.	A . ace - Amaric	an Indian
items iner na	F.	1 Never Married 2 Married	Armed Forcas? 1 ☐ Yas 2 ☒ No	ii iii 0,0.	It Yas,	specify Cub	Hspanic Origin? (S an, Mexican, Puar	to Rican, atc.)	Bi	lack, Whita,	
r. or	by	3 Widowad 4 Divorced	If Yas, Giva Yaar or Datas:		1 🗆 Y	es 2🗓 No	Specify:		Spec	eity: Whi	ite
natural', edical Exe	8	15. Dacedant's Ed		18e.	Decedant's	Usual Occup	petion		16b. Kind ot		
- 400	Be Completed	(Specify only highest gra-	da complated)		(Giva kind of lifa. DO No	of work dona OT use ratire	during most of wo	rking			l Capital
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a it	0	17. Fethar's Nama (First, Middla, Last)				по-ре		me (First, Middle	1		12116
D 0	To B	Robert Lee Raff					Ruth A	rmacost			
is marked other traumetic event, in	-	19a. Informent's Name/Ralationship (7	vpe. Print)	19b	. Mailing Add	drass (Street	and Number or R		er City or Tow	n Steta Zir	Code)
tra tra		Gloria J. Skaggs					Parkway,				
reciti and mental hygiena. Item 27 is marked other than other traumatic event, tha	ŀ	20a. Mathod of Disposition		20b. Placa of	Disposition	(Nama of		Dete	20c. Location	J.	
5 = 5		1 Burial 2 Cramation 3				or othar pla	'				
ortant ortant injury	-	4 Donation 5 Other (Specify 21. Signettus of Funeral Service Licen.		Congre			etery ,	2/19/98	Washir	igton,	DC
Papa mpo any i		21. Signatura di Funeral Service Udan	1			na and Addra	sch's So	ne Fune	cal Hom	A D /	٨
		Henry J.	treat		4739	Balti	more Ave	nue, Hya	attsvil	le, MI	20781
		23a. Part 1. Enter the diseasa, or companion, or heart failura. List only of	licetions thet caused the ona causa on each lina.	a daath. Do r	not antar tha	mode of dylr	ng, such as cardia	c or raspiratory a	rrast,		Approximeta Intarvai Between
ysician	1		00			<i>^</i> -				1	Onsat and Death
Aedical aminer		Immediete Causa (Final disaasa or condition rasulting in daath)	· INFR	MAN	C F	FUR	91 G	ANCE	R	į,	1 YEAR.
	_	rasuking in daatily	Du Du	e to (or as e	consequence	e ot):	5				0 (
Sit	Examiner		b NEU	TRO	PEN.	10	15VE	R		10	2 mers
physician end s the burial-transit	xan	Sequentially list conditions, if any, leeding to immediate	Du	e to (or as a	consequence	a ot):					
clan	<u>=</u>	Sequantially list conditions, if any, leeding to immadieta causa. Entar Undarlyling Causa (Diseese or Injury that initiatad events	C								
the	edicai	that initiated events rasulting in death) Last	Du	a to (or as a c	onsequance	ot):					
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ettend for us	lan		u								
ed by the ettendir detached for use	Physician/	Part II. Other significant conditions co	ntributing to death but n	ot rasulting In	tha undarly	ing cause giv	ven in Pert I.	23b. Did	tobacco use c	ontribute to	the causa of death?
d by	P.							10	Yes 20 No	3 Proi	bably 4 Unknown
5.8	þ					·					
been si should	Completed								an autopsy	24b. Wa	ara autopsy findings ailabla prior to
2 sh	pie									CO	mplation of causa daath?
s certificate has director, pege 2	E							10	Yas 20 No	15	Yas 2XNo
tor, p	Bec	25. Wes case referred to medical					28 Place at Da	ath (Check only	/		3740
direc	2 B	axaminar?	Hospital:	2□ ER/Ou	tnationt 3	DOA Oth		doma 5 ☐ Resi		thar (Snacif	(4)
		27. Manner of Death	28a. Deta of Injury (Month, Dey Yo		ima of	28c, Injur		28d. Describe			77
To the Funeral Director: After completely filled in by tha funa	9	1 ⊠Natural 5 ☐ Panding 2 ☐ Accidant invastigation	(Month, Dey Yo	ear) In	njury M		rk? Yas 2∐No		-		
y th	20	3 ☐ Suicida 6 ☐ Could not be	28a. Placa ot Injury	- At homa, ta	rm, straat, ta	etory, offica		28t. Location	Straat and Nun	n <i>ber or Rura</i>	il Routa Number,
d in	Certification:	4 Homicide	building, etc. (Specify)	_	,,		City or To	wn, State)		
To the Funeral Director: After the completely filled in by tha funaral		29a, Certifiar 1X Cartifying Phy	sician: To the best of m	v knowledge	death occu	rred at the tir	me deta and place	and due to the	causa(s) and r	mannar ac c	teteri
To the Funeral D completely filled I	edicai	(Check only 2 Madical Exam	Inar: On the basis of ax	amination end	d/or invastiga	ation, in my o	pinion, daath occi	rred et tha tima,	data and place	and dua to	the causa(s)
oth	ŝ	29b. Signatura and title of certifiar		•		29c. Licens	e number		29d. Dete sign	ned (Month.	Day, Yaar)
-0		C A	/	10		0)					
7	-	7					70///5	PARKWI	- 10	10	
UI		30. Name and address of person who c	omplated cause of deet	(Item 23e) (Typa, Print)	AAN	NUER	PARKWI	24 20	000	\n
		STITE VALVA	TIN VIEW VI	70 /0	70 0 77	, , ,	OREEN	BELT	1110	001/	10
Stat	е	31. Data tiled (Month, Day, Year)	32. Registrar's	Signatura							

applicated in 1889 135

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nema (First, Middla, Last) 3. Tima of Death 2. Date of Death Month **Physician** 09:00 FEBRUARY 12 FLORENCE E. RHODES /Medical 4b. City, Town, or Location of Death 4a. Fecility Nama (If not Institution, give street and number) 4c. County of Death Examiner 4820 HEATH STREET CAPITOL HEIGHTS GEORGES PRINCE If Under 1 Year If Undar 24 Hrs. 8. Dala of Birth (Month, Day, Year) Birthpleca (Stata or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F 578-44-6178 89 Yrs. Director Virginia Usual Rasidanca of Decedent filed within 72 hours efter deeth with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "netural", or items 23a or 28a-f ahow the Modical Exampler must be notified at Md. P.G. 17 Yes 2 No Director Capitol Hqts. 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4820 Heath St. 20743 U.S.A. Funeral Was Dacedent of Hispenic Origin? (Specify Yas or No-II Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1 Never Married 2 Married 21215-0020 1□ Yas ♣□ No Specify: by Black 3℃ Widowad 4 Divorced Completed 15. Decedant's Education (Specify only highast grada complated) Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry nd Mental Hygiene. merked other than Elamantary/Secondary (0-12) Collaga (1-4or 5+) Domestic Private Industry 12th nt of Health end Mental Hygin I it itsm 27 is marked other or other traumetic event, Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumame) Be Peges 1 end 2 should be nent of Health end Mental William Mosby Columbia Winston 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 4815 Heath St., Cap. Hgts., Md. Gary L. Swilling/Nephew 20b. Placa of Disposition (Nama of comatary, crematory or other place)
Ft. Lincoln Cem. 20a. Mathod of Disposition 20c. Location - City or Town, Slete 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel Irom Stata permit. Pege Department of Important: If any injury or 2/17/98 Brentwood, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licansee 22. Nama end Addrass of Facility H.S.Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E. Xany W. Beat 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onsat and Death **Physician** /Medical Immadiata Causa (Finel . ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disaasa or condition rasulting in daath) Examiner Examiner The law requires that the death certificate be executed the buriel-trensit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequanca ol): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown of Vital Records, by director, page 2 should Completed 24b. Wara eutopsy findings available prior to 24a. Was an autopsy completion of causa ol daath? 1 Yas 1 Yes 2 No or Attending Physician: Be 25. Was casa ralarred to medical 26. Placa of Daath (Check only ona) axaminar? 1 Yas 2 No Othar: 4 ☐ Nursing Homa 5 Rasidanca 6 ☐ Other (Specify) Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this hours efter death. nerai Director: After this y filled in by the funeral di 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Division 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa ol Injury - At homa, larm, streat, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours e To the Funeral C 29a. Cartifiar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature/and litla of cartiliar 29d. Data signed (Month, Day, Year) 29c. Licansa number 30. Nama and addrass of person who cor ed causa of daath ftam 23a) (Type, Print) 3001 HOSPITAL DRIVE, MARYLAND GOLLE 32-Registrar's Signetura 31. Data lilad (Month, Day, Year) State FEB 19 199 Registrar



Physiciar /Medica Examined	n	 Decedent's Name (First, Middle, Last, 			tificate of	Death		. No. 🧷 🔾	U,	1000
Examiner Funeral		James W. Rierson,					2. Date of Death Month February	Day 22 1	Year 998	3. Time of Death 8:20 AM
	_	4a. Facility Neme (If not institution, give	street and number)			4b. City, Town, or Lo		4c. County	of Death	
	4	2122 Liberty Grove 5. Social Security Number 6. Sec		to the same to at high do at	If Under 1 Year	Colora If Under 24 Hrs.	0.0.4.10.4	Cecil		
Director			M 2□F	ge (In yrs. last birthday) 43 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Mar. 31,	^(ear) 1954	9. Birthpl Coun Maryk	ace (State or Foreight) and
the Maryland 28a-f show molified at		10a. State 10b. County		10c. City, Town or Lo	cation				10	Od. Inside City Limit
vith the Maryle to 28a-f short be notified at	9010	Maryland Cecil 10e. Street and Number		Colora	10/ 7/ 0 /			2000		1 ☐ Yes 2 💢 N
with with	5	2122 Liberty Grove	Dd		10f. Zip Code 21917			. Citizen of V	Vhat Coun	try?
items 2	runeral		12. Was Decedent	Ever In U,S. 13. V		Hispanic Origin? (Spe an, Mexicen, Puerto		USA 14. Raci	e - America	an Indian,
0 0 0	by rur	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X if Yes, Give Year or Dates:	No	Yes, specify Cub		Rican, etc.)	Specify	k, White, e	ite
naturel',		15. Decedent's Edu	cetion	16a. Deced	ent's Usual Occup	pation	16	b. Kind of Bu	_	
led within 72 ho hyglene. her than *natur. nt, Ire Medical	ubie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or:	0+)		pation during most of worki d)	ing			
offied with al Hyglene. other than vent, ire M	5	12		Mecha	nic			ito Bo	_	
e de la la la la la la la la la la la la la	מ	17. Fether's Name (First, Middle, Last) James W. Rierson				18. Mother's Name		iden Sumam	10)	
d 2 should be th and Mental 7 is marked o	2	19a. Informent's Name/Relationship (Ty	no Point)	10h Mailin	a Addres as /Otros	Audrey A			01.1.	0.41
d 2 s lth an lth an trau		Patricia E. Riers				Grove Rd.				Code)
permit. Pages 1 and 5 Department of Health Important: if Item 27 i any injury or other tro	1	20a. Method of Disposition	. 0	20b. Place of Disportant Commetery, crem				c. Location -		wn, State
Peger ent o		1 ☐ Burial 2 🕅 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			. Inc. 2				
Physician /Medical Examiner		23a. Part Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition	cations Mat cause e cause on each i	11 death. Do not ente	1 S. Que	iss of Fecility d Funeral en St. R. ng, such as cerdiac o	ising Sur	n, MD	21911	Approximate Interval Between Onset and Death
<u> </u>		resulting in death)		Due to (or as a conseq						
ficate be physicials the burned call	- Carcal	Sequentially list conditions, if any, leading to Immediate cease. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest		Due to (or as a consequence to (or es e consequence)						
at the death certing by the attending etached for use a Physician/M	Sicial	Part II. Other algnificent conditions con	tributing to death b	ut not resulting in the ur	derlying ceuse giv	ven in Part I.	23b. Did toba	occo use cor	ntribute to	the cause of deat
es that the de igned by the a be detached by the about by the about by Physical by Physica							1 🗆 Yes	2 No	3 🗆 Prob	ebly 4☐Unkno
aw 2 s t	hieren						24a. Was an a performe	autopsy d?	ava	re autopsy findings ilable prior to apletion of ceuse leath?
The late he page	5						1 ☐ Yes	2 2 No	1 🗆	Yes No
ysicien: The s certificate director, pag	:	25. Was cese referred to medicel examiner?			100	26. Place of Death	(Check only one)			
T di di		27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry Year) 2 ER/Outpatien 28b. Time of Injury	28c. Inju	y at // // // // // // // // // // // // //	me 5 Residence 28d. Describe how)
		2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, stre c. (Specify)		Yes 2 □ No	28f. Location (Stree City or Town, S	et and Numbe State)	er or Rurai	Route Number,
Hospital 24 hours Funerel Itely filled	3	29a. Certifier (Check only one) Ki Certifying Phys	Iclan: To the best of the basis of and manner sta	of my knowledge, death examination and/or Invated.	occurred at the tirestigation, in my o	me, date and piace, a pinion, death occurre	and due to the caused at the time, date	se(s) and ma and place, e	nner as sta	ated. the cause(s)
To the comple		29b. Signature apply talk of phylities	1/		29c. Licens \$\mathcal{D}35\$			Date signed		Pay, Year)
	1	10. Name and address of person sho co	muleted deuse of d	eath (Item 23a) (Type,	Print)	ND 21	1921			
		31. Date tiled (Month Day, Sear) FEB 23	B 32. Registra	ar's Signature	1	k				

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State of Maryland / Department of Health and Mental Hygiene

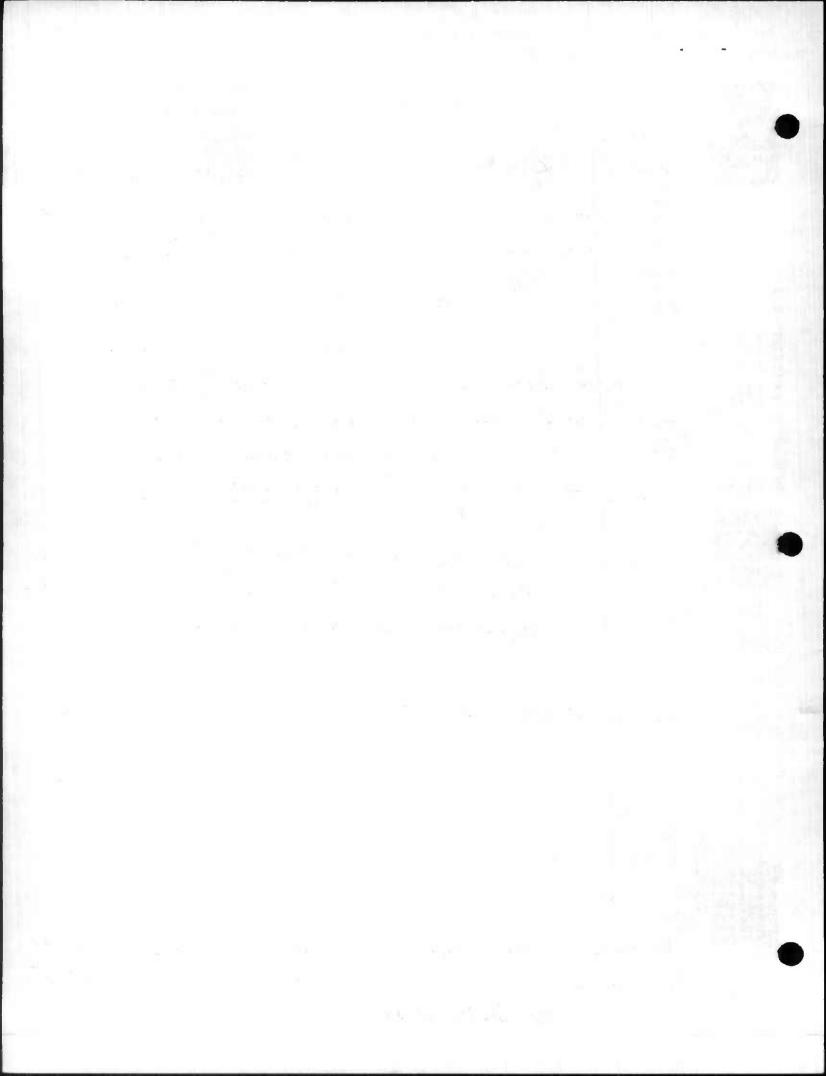
Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 6 Day **Physician** Month 2 MICHAEL JOHN ROLES 8:08PM /Medical 4e. Facility Name (if not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 9901 Jerry Mack RD Ocean City Worcester 6. Sax 1 M 2 F If Undar 1 Yeer If Under 24 Hrs. 9. Birthpleca (Stata or Foraign Country) England 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) 11/18/45 7. Aga (In yrs. iest birthday) **Funeral** Deys Yrs. Director 249-02-9098 Usuel Rasidanca of Dacedant the Maryland 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, are Medical Examiner must be not red MD Worcester Ocean City 1 Yes 2 No Director 10e. Streat end Number 10f. Zip Coda 10g. Citizen of Whet Country? USA 9901 Jerry Mack RD 21842 pernit. Peges 1 and 2 should be filed within 72 hours effer death Department of Health end Mentel Hygiene. Important: If frem 27 is merked other then "natural", or frems 23 any injury or other traumetic event. Funeral 12. Wes Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1 ☐ Yas 2 🔀 No If Yas, Giva Yeer or Detas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Collaga (1-4or 5+) Woodworking 11 Carpenter 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Doris Kathleen Mills William Andrew Roles 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stete, Zip Coda) Barbara E. Roles / Wife 9901 Jerry Mack RD Ocean City, MD 21842 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriai 2 Cremation 3 ☐ Ramoval from State 4 Donation 5 Othar (Specify) Cape Henlopen Crematory 2/12/98 Frankford, DE 22. Neme end Addrass of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811 108 William St. Berlin, MD as of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, list only one cause on each line. **Physician** /Medical immediata Causa (Finat Malignar/ Mesothelio ma disaasa or condition rasulting in death) Examiner Examiner ettending physician end for use as the buriel-transit Hospital or Attending Physician: The lew requires that the death certificate be executed thours after death.
 Funeral Director: After this certificate has been signed by the ettending physician and etely filled in by the funeral director, page 2 should be deteched for use as the burial-transit etely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Sequantially list conditions, if any, leeding to immadiata causa. Entar Underlying Cause (Disaase or Injury that initiated events rasulting in daath) Last Dua to (or es e consequance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequanca of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24a. Was an autopsy performed? 24b. Wara autopsy findings availabla prior to completion of cause of death? Completed 1 Yas 2 No 1 □ Yes 2 □ No 25. Was casa rafarred to medical Be 26. Placa of Death (Check only ona) axaminar? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 Suicide Location (Streat and Number or Rural Routa Number, City or Town, Stata) Piaca of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Dis completely filled in 29a. Cartifian 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha time, data end place, end due to the cause(s) end manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) 29b. Signature and fittle of oprtifier 29c. License number 29d. Data signed (Month, Day, Year) M.D. FCG. 10, 1998 0 30690 30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print) E. Corroll St. Salisbury MD. Martin 1,0. 31. Date filed (Month, Day, Yaar) 32. Registrar's Signatura State Julia Davidson Randelle Registrar FEB 1 2 1998

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State of Maryland / Department of Health and Mental Hygiene

						Certificate of	f Death	Reg	. No.	U	1062
			1. Decedent's Name (First, Middle, L	ast)				2. Date of Death		Vaar	3. Time of Death
	Physici /Medi		RUTH	PHYLLIS		ROGERS		Month FEBRUARY	^{Day} 20,19	Year 98	06:57a.m.
	Examir		4e. Fecility Neme (If not institution, gi	ve street end number)			4b. City, Town, or L	ocation of Deeth	4c. County	of Death	
			Calvert Memo	rial Hospit	:a1		Pr. Fred	derick	Caly	ert.	
	Funeral	1	5. Social Security Number 6.		yrs. last bir	Months Dev	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, Y			lace (State or Foreign
	Director		113-09-3593	79)	Yrs.		8/19/19			Jersey
	pue *		Usual Residence of Decedent 10a. State 10b. County	100	. City, Tow	n or Location				10	0d. Inside City Limits
	Manyl f sho	0	MD Colum								17 Yes 2 □ No
	the 284	Director	MD Calve 10e. Street and Number	rt F	lunti	ngtown 10f. Zip Code		100	. Citizen of W	/hat Count	try?
	3a or	Ö	1506 Wilson D								20
	ms 2	Funerai	1506 Wilson R	12. Was Decedent Ever	in U,S.	13. Was Decedent of	3 9 f Hispenic Origin? (Sp Joan, Mexicen, Puerto	pecify Yes or No-	US 14. Race	A - America	an Indian,
0	offer of the parties		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No				Rican, etc.)	Black	k, White, e	etc.
02	af', o	by	3 N Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□ Yes X□ N	o Specify:		Specify:	whi	te
2-0	72 hours efter death with the Marylend netural; or items 23s or 28s-f show signs Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr		16e.	Decedent's Usual Occ (Give kind of work don	upation	king 16	Sb. Kind of Bu		
21215-0020	within ene. than "	nple	Elementary/Secondery (0-12)	College (1-4or 5+)		life. DO NOT use retir	red)	· · · · · ·			
	Hygier ther th	S	12			Bookke	eeper				ership
and	the fill H	Be	17. Father's Name (First, Middle, Las	")			18. Mother's Nam	ne (First, Middle, Ma	iden Sumem	e)	
ž	should ind Men marks umatic	2	Chester A. Ba:					lle Dell			
Maryland	12 sh h and r is n traun		19a. Informant's Name/Relationship			. Meiling Address (Stree					
	1 and Heelth em 27 ther to		Kenneth A. Roge		h Place of	11 Foxhou	and Ct.,	Severn,	MD 2 c. Location -	1144	Etata
٥	Peges nent of the		1 ☐ Burial 2X Cremation 3 [Demoved from State	cemete	ry, cremetory or other pa					
altimore,	it. Pertrant		4 Donation 5 Other (Speci	fy) M	letro	politan C	rematory	2/23/9	8 Ale	х.,	VA
Ba	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at ance.		21. Signature of Funeral Service Lice	nsee .		22. Name end Add		ymond F			
			23a. Part 1. Enter the disease, or con	Mayon		P.O. Bo	x 121, I	unkirk,	MD 2	0754	
			shock, or heart failure. List only	one cause on each line.	death. Do	not enter the mode of d	ying, such as cerdiac	or respiretory erres	t,		Approximate Interval Between Onset end Death
	Physician /Medical		Immediate Cause (Final	0							Chiser and Death
	Examiner		disease or condition resulting in death)	a Cardio	ic /	vrest					
		er		a Cardio Due Respirat	to (or as a	consequence of):					
	uted d ansit	Examiner	C	b. Kespiva	ory	consequence of):				- 1	
ń	exec an en riel-tr	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due	10 (01 85 a 1	consequence or).				!	
68760,	The law requires that the death certificate be executed ate has been signed by the ettending physician end page 2 should be deteched for use as the bunel-transit	edicai	Cause (Disease or Injury that Initiated events resulting in deeth) Last	cDue t	o (or as a c	consequence of):					
9	e as ti	Med	resulting in deepin Last			,				i	
ROX	eath ce ettendi for use	an/l		d						1	
	es that the death ce igned by the ettend be deteched for us.	Physician/	Part II. Other significant conditions	contributing to death but not	resulting In	the underlying ceuse g	given in Part I.	23b. Did tobe	acco use con	tribute to	the causa of death?
P.0.	d by	Phy	Chanic al	structive	0,1	decision de	0.50-00	1 Yas	2 □ No	3 Prob	pably 4 Unknow
Š,	signe be d	by	CHOILEON	Stractive	141	monary	DIXON				
5	v require been si should I	ted						24a. Was an performe		ava	are autopsy findings
e O	hes by ge 2 st	npie								of c	npletion of ceuse death?
=	The sate ?	Completed						1 ☐ Yes	20 No	1□	Yes 20 No
118	oertificate rector, pag	Be	25. Was cese referred to medical examiner?					th (Check only one)			
5	physic this c	2	1 Yes 2 No		2 ER/Ou	tpatient 3LI DOA		ome 5 Residen		-	9
	Attanding Physician: or death. actor: After this certific. by the funeral director,	inol in	27. Manner of Death 1 ■ Neturel 5 □ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. 1	Time of 28c. Inj		28d. Describe how	injury occurre	ed	
<u>s</u>	death death stor: , the	cat	2 Accident investigation 3 Sulcide 6 Could not be	One Place of Injury	N hama fa		☐ Yes 2 ☐ No	28f. Location (Stre	at and Number	ar or Dum	I Florita Atumbus
Division of Vital Records,	or A after Dirac	Certification:	4 ☐ Homicide determined	building, etc. (Sp	ecify)	rm, street, factory, office	9	City or Town,		er or nurer	House Number,
	To the Hospital or Attending Physician: The I within 24 Junus after death. To the Funeral Diractor: After this certificate he completely filled in by the funeral director, page		29a, Certifier Cartifying Pl	nyaicien: To the best of my	knowledne	death occurred at the	time date and place	and due to the cau	se/s) and mai	nner as st	ated
	Hos 24 h Fur letely	edical	(Check only 2 Madical Example)	niner: On the basis of exam and manner stated.	nination an	d/or Investigation, in my	opinion, death occur	red at the time, date	e and place, a	ind due to	the cause(s)
	vithir To th	Me	29b. Signature and title of certifier			29c. Licer	nse number	290	I. Dete signed	(Month, L	Dey, Year)
			OARS.	Mr. Win	>	DC	15735		2/20	158	
	7	-	30. Name and address of person who	completed cause of death i	Item 23a) (5-100/	/ 6	
	1			rine Brophy, N			aryland 2	20754			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	igneture	0 0 0					
	Registr	ar	FFR 2	3 1000 Inhi	davel	ion Tardall					

		1 December 1 Name (First 14)	tille (ant)		Cei	tificate of	Death		Reg. No.	8 0/063
Physici /Medi		Decedant's Nama (First, Mid	GEORGE	DAWSON	SLAC	UM, JR.		2. Data of De Month Februa	ary 22 1	3. Tima of Dec 998 0800
Examir	ner	4e. Facility Nama (If not institut 12 Bay He	The second second	um <i>ber)</i>				or Location of Deed oridge		of Death hester
-uneral Director		5. Sociel Sacurity Number 220-26-1661	6. Sax M 2□ F	7. Age (In yrs. 75	lest birthday) Yrs.	If Under 1 Year Months Days	If Undar 24 H Hours M	n. (Month, D	rth ay, Year) 0 1922	9. Birthplaca (Stata or Fo Country) Maryland
ž ==		Usual Residence of Decadent 10a. State 10b. Coun	ty	10c. Cit	ty, Town or Lo	cation				10d. Insida City Li
F S S	to	MD Dor	chester			Camb	ridge			1 □ Yes 2
or 28a	Director	10e. Streat and Number				10f. Zip Coda			10g. Citizen of V	What Country?
23a			Bay Heigh				21613		U.S.	
vio wenter hyperia. 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Naver Married 2 Maried 2 Married 2 Married 2 Divorce	Armed F arriad 121 Yes	cedant Ever in U forcas? 2 ☐ No liva Detes: WW I		Vas Decedent of Yas, specify Cut □ Yas 20 No	dispenic Origin? an, Mexican, Pui Specify:	(Spacify Yes or No arto Ricen, atc.)	o- 14. Rac Blac Specify	e - Amarican Indian, ck, Whita, atc.
etura	ted	15. Daced	ant's Education			lent's Usual Occu	pation		16b. Kind of Bu	usiness/industry
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dothe	Be	17. Father's Name (First, Middl	-	01				ama (First, Middle		
natic	၉	George	Dawson	Slacu	1			oberta	Thoma	
27 la n		19a. Informant's Name/Relation Mrs. Sue Cusi-		iter		Donerin		Ru <i>ral Rou</i> ta Numb hoenix M		Stata, Zip Code)
othe		20a. Method of Disposition		20b. F	Plece of Dispos	sition (Nama of natory or other pla		Data		City or Town, Stata
nt: H		Donation 5 Other				vn Cemet		4-1998	Cambrid	lge, Maryland
Important: if any injury o		21. Signatura of Funaral Sarvio	e Licensea L. R. M.	- A	Th	Nama and Addr	eral Ĥo		VD 21612	
-		23e. Pert1. Entar tha diseasa, shock, or heert failura. Li	or complications that	caused the daat				nbridge N ac or respiretory		Approximate
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	P.	The state of the s		Due to (d	or as a conseq	uence of):				5 sunu
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physician end s the burial-transit		Sequantially list conditions, if any, leading to Immediate ceuse. Enter Underlying Causa (Disease or Injury	Ha	PERTE	NS10		FACT	DISEMS	E	
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in b		4 ☐ HomicIda deter	build	ling, atc. (Specif	y)	eat, factory, office		City or To	wn, Stete)	er or Rurel Roula Number,
Funeral Cletchy filled	edical	29a. Certifiar (Check only one) 2 Medica	ing Physicien: To the i Examinar: On the t	a bast of my kno pasis of axamine nnar statad.	wledga, death tion end/or lnv	occurrad at tha ti astigation, in my	ma, data end ple ppinlon, daath oo	ce, end dua to tha curred at tha time,	causa(s) and ma dete and place,	nner as stated. and dua to tha cause(s)
To the comple	Me	29b. Signature and title of certif	-	That status.		29c. Lican			29d. Dete signa	d (Month, Day, Year)
		Muchaela	Meshou	DE M	· K	1	-1660	7	FEBRUA	114 23, 199 DOE MARYO
		30. Nama and address of perso		Sa of death (Item		Print)	n =1.1	4)		216
					1/1/1 L	1	2 111/11	1 13	O Buck IL	MAZZ WINNIII



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Yaeı Month **Physician** Christine Schleehauf February 18, 1998 6:30 pm /Medical 4a. Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Beltsville Elderly Care Center Beltsville Prince George's If Under 1 Yeer If Under 24 Hrs. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Dete of Birth (Month, Day, Yeer) **Funeral** 1□M 2ŒF Months Days Hours 214-30-0782 Yrs. **Director** 94 Nov. 30, 1903 Germany Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director Maryland Prince George's Beltsville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ŏ Items 23a 13022 Ingleside Drive 20705 U.S.A. Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yeer or Dates: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Rece - American Indien, Bleck, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours effer (Depertment of Health and Mental Hygiene. Important: If fiem 27 Is marked other than "natural", or flee any Injury or other traumatic event, the Hed call Examinal 1 Navar Married 2 Married 1 ☐ Yas 2 🖺 No Specify: Specify: P 3 Widowed 4 Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Owner Restaurant 17. Fether's Neme (First, Middla, Last) 18. Mother's Nama (First, Middla, Meidan Sumame) Be Johann Shreiber Kunnigunda Rackulmann 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Route Number, City or Town, Steta, Zip Code) Olga Cable - Niece 4512 Oliver Street, Riverdale, Maryland 20b. Place of Disposition (Neme of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burlal 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Prospect Hill Cemetery 02/23/98 Washington, DC 21. Signatura of Funeral Service Licensee 22. Name end Addrass of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 23a. Part1. Entar tha disease, or complications that caused tha death. Do not entar the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 20781 Approximate intarval Batween Onsat end Daath **Physician** /Medicai Immedieta Causa (Final SEVERE CONGESTIVE HEART FAILURE disaasa or condition resulting in death) 1 Week Examiner Dua to (or as a consequence of): Examiner CONGESTIVE CARDIOMYOPATHY 8 years ettending physician and for use as the buriel-trensit Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated avants rasulting in daath) Last Due to (or as a consequence of) HYPERTENSIVE HEART DISEASE 20 years Physician/Medical Dua to (or as a consequance of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Renal Failure, Atrial Fibrillation þ been sig 24b. Wara autopsy findings evelleble prior to Completed 24e. Wes en autopsy completion of cause of death? page 2 1 Yes 2 🔯 No 1 ☐ Yas 210 No certificate director, Be 25. Was cesa rafarrad to medicel 28. Placa of Death (Check only one) axaminar? To Hospitai: Other: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this the furneral 27. Manner of Deeth 28a. Dete of Injury (Month, Day Yaar) Certification: 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Affer 5 Pending invastigation 1 X Neturei death 1 ☐ Yas 2 ☐ No after death Director: 2 Accident 3 Sulcide 6 ☐ Could not ba datarmined Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) Location (Street end Number or Rural Routa Number, City or Town, Stata) B 4 Homleida To the Hospital within 24 hours a To the Funeral C 1 McCertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner es stetad.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Cartifian Medicai (Check only onel 29b. Signatura and title of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) .98 D22755 NU 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) Christine Delima, M.D., 7350 Van Dusen Road, #260, Laurel, Maryland 31. Date filed (Month, Day, Yaar) 32. Ragistrar's Signatura State

M. driver R

FEB 2 0 1998

Registrar

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed

Box 68760.

P.O. I

Records,

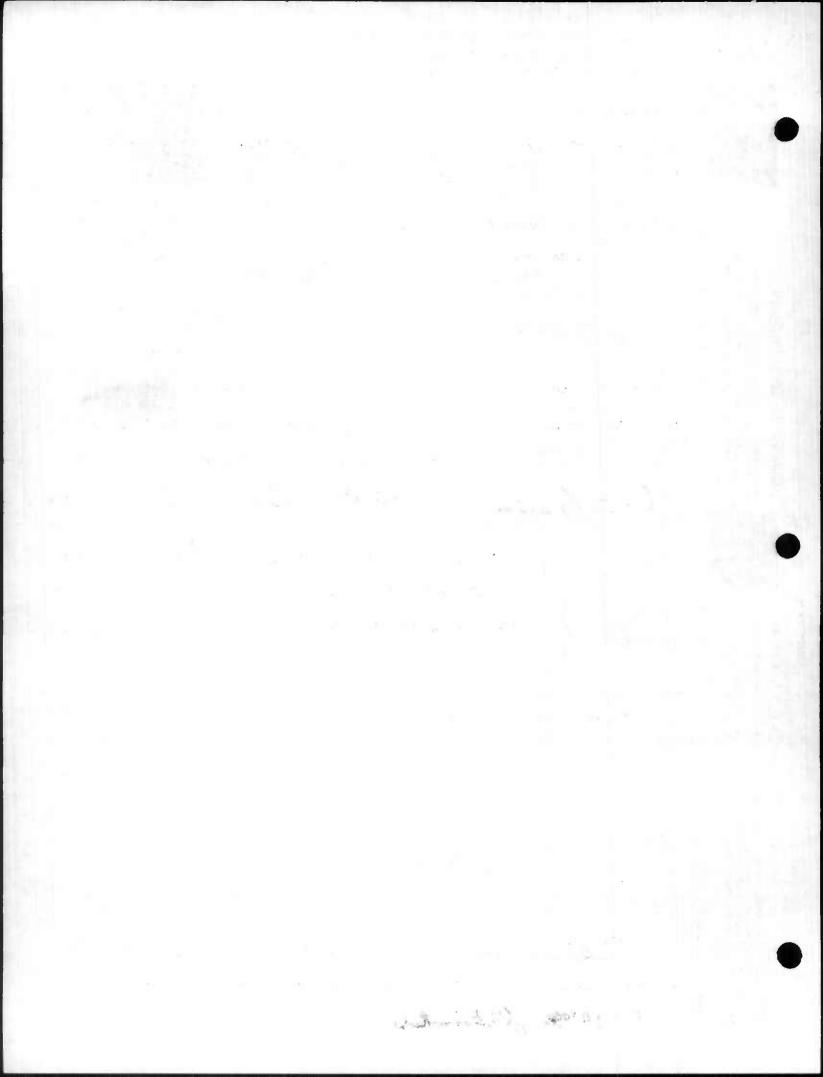
of Vital

Division

Attending Physician:

8

Hospital



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** February 11, 1998 10:20 PM Dorothy /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Washington Adventist Hospital Takoma Park Montgomery | Id Note | 1 Vear | If Under 24 Hrs. | 8. Data of Birth | 9. Birthplaca (Stata or Foraign Months | Days | Hours | Min. | Nov. | 11, 1911 | 9. Birthplaca (Stata or Foraign Washington, DC 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 1□M 24 F 579-48-1849 86 Yrs. Director Usuai Rasidence of Decedant the Meryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits show 7 is marked other than "natural", or items 23a or 28a-f shor treumetic event, the Maxical Examiner must be notified at ₩ Yes 2 No Director MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 104 Geneva Avenue U.S.A. Funeral 12. Was Decedant Evar In U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, White, atc. 72 hours after 1 Nevar Marriad 2 Married 1 Yas 2 No If Yes, Give Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: à Specify:Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within 7 nent of Heelth and Mental Hygiene. nt: If Item 27 Is merked other then "r Elemantary/Secondary (0-12) Coilega (1-4or 5+) 12th D.C. General Hospital Nurse 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Rebecca Dixon Robert Dixon 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) permit. Peges 1 and 2 s Department of Heelth an Important: If Item 27 is: any Injury or other trsu once. Earl C. Starke - Husband 104 Geneva Ave. Silver Spring, MD 20910 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Lincoln Memorial Cemetery 2-18 Suitland, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signetura of Funarai Sarvice Licensas 22. Nama and Address of Fecility
Marshall's Funeral Home, Inc. aus 4217 9th Street N.W. Washington, DC 20011 23e. Part) Entar tha disaase, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate interval Batween Onsat and Death **Physician** /Medicai immediata Causa (Finai 2 DAYS KenDrag disaasa or condition rasulting in daath) Examiner Examiner physicien end s the burief-transit xcespatio The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last Dua to (or as e consequence of) P.O. Box 68760. Physician/Medicai Dua to (or as a consequance of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by detect 1 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? page 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this cartifica stely filled in by the funeral director, I 25. Wes casa rafarrad to medical 26. Piaca of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify) 2 1 ☐ Yas 2 ☑ No 1 ☑ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of injury (Month, Day Year) Medical Certification: 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Naturai 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be datarmined 3 ☐ Sulcida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Certifia: Certifying Physician: To the bast of my knowladga, daath occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and mannar stated. To the Hosp within 24 hou To the Funel completely fil 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 45660 complated causa of daath (Item 23a) (Type, Print) Michell ville 31. Date filad (Month, Day, Yaar) State FER 17 199 Registrar

Marine Marine 1877

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 02: 12 PM 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dev Month Veer JONATHAN SMITH PEBRUARY 16, 1998 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth CHEVERLY PRINCE GEORGES HOSPITAL CENTER PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Months Deys Hours 1∏M 2□ F 219-48-3785 50 Yrs. 01 - 14 - 48Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Landover 15 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 717 Tola Court 20785 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 X No Specify: Black. Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Bus Driver 12th Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Dennis Smith Marie Pender 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Marie Smith/Mother 1632 Walker Mill Road, Capital Heights, MD 20743 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veteran's Cem. 2/23/98 Cheltenham, Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility J. B. Jenkins Funeral Home Na 23a. Pert 1. Enter the discusse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate intervel Between Onset end Deeth Immediete Cause (Finel . HYPERTENSIVE ARTERIOSCLEROTIC CARPIGNASCULAR DISEASE diseese or condition resulting in death) Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es a consequence of): 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MELLITUS

Physician /Medicai Examiner

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signed by t

page 2

Hospital or Attending Physician: The law requires to thous state death.

Ehreral Director: After this certificate hes been signs for the first of the things

pue

physician

the death certificate be executed

Box 68760.

Records, P.O.

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

10a. Stete

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at

Hygiene.

permit. Peges 1 and 2 should be file Department of Health and Memel Hy Important: If Item 27 is marked other any injury or other trauments

the Meryland

72 hours efter

Baltimore, Maryland 21215-0020

Examiner Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

Physician/Medical Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. DIABETES þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed CHRONIC RENAL FAILUKE 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 86 26. Place of Deeth (Check only one) exeminer? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ inpatient 2 XER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of tnjury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Netural 5 Pending 1 Yes 2 No 2 ☐ Accident Investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rure! Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier Medical 1 Certifying Phyefcfan: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner as steted. (Check only one) Madical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) 29c. License number 29d. Date signed (Month, Dey, Year)

FORRWARY 16, 1998

3001 HOSPITAL 974VE, CHEVERLY MARYLAND 20785

PME

o 24 hou. • Funeral Dir-tilled F 121

State Registrar

31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

MD

heland address of person who completed cause of deeth (Item 23e) (Type, Print)

MARIO F. GOLLE

FEB 18 1998

TES IN 1891. John Camer to

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 9, 1998 Yeer 1:15 Am SPEIGHT 4b. City, Town, or Location of Death 4e. Facility Neme (If not institution, give street end number) 4c. County of Deeth PRINCE GEORGES HOSPITAL CHEVERLY, MD PRINCE GEORGES 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. (Month, Dey, Year) OCT 13, 1948 9. Birthplece (State or Foreign Country) WASHINGTON, D. 1⊠M 2□ F 10b. County 10c. City, Town or Location 10d. Inside City Limits WASHINGTON, D.C. ty Yes 2 □ No NONE 10f. Zip Code 10g. Citizen of Whet Country? 20032 O STREET S.W. USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) ROOFING ARTISAN ROOFER 18. Mother's Name (First, Middle, Majden, Surname)
WILLIE MAE SHEPARD JAMES A. SPEIGHT

12th 17. Fether's Name (First, Middle, Last)

Physician

/Medical

Examiner

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any fujury or other traumatic event, the Madical Examiner must be notified as once.

Physician /Medical

Examiner

physician and s the burial-tran

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signed t

page 2 s

funeral director.

filled in by

certificata

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

P.O. Box 68760.

Division of Vital Records.

Examiner

Physician/Medical

à

Completed

Be

2

Certification:

Medical

Baltimore, Maryland 21215-0020

THOMAS

5. Social Security Number

578-65-5683

D.C. 10e. Street end Number

67

10a Stete

Director

Funeral

ρ

Completed

Usuel Residence of Decedent

19e. Informent's Neme/Reletionship (Type, Print) SAMUEL SPEIGHT (BROTHER) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) $1833~EAST~CAPITOL~ST \cdot S \cdot E \cdot$

1 Nuriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

FEB 17,1998 LANDOVER, MD HARMONY MEMORIAL 22. Name end Address of Facility
RALPH WILLIAMS FUNERAL SVC

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List *only* one cause on each line.

CARDIOMEGALY

517 11th STREET S.E.

Immediete Ceuse (Finel diseese or condition resulting in death)

20e. Method of Disposition

ARREST (ARDIO-RESPIRATORT Due to (or es e consequence of):

20b. Plece of Disposition (Name of cemetery, cremetory or other plece)

Due to (or es e consequence of)

Due to (or es e consequence of)

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest

Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death?

20c. Location - City or Town, Stete

1 Yes 2 No 3 Probably 4 Unknown

Approximete Intervel Between Onset end Deeth

Hemonrage Left frontal

24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed?

completion of cause of death?

1√Yes 2 No

1€ Yes 2 No

25. Wes cese referred to medical exeminer? 1 Yes 2√ No

27. Manner of Deeth

2 Accident

4 Homicide

3 ☐ Sulcide

29a. Certifier

Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 Yes 2 No

5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

26. Plece of Deeth (Check only one)

29b. Signeture end title of certifier Schholsve

D50686

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

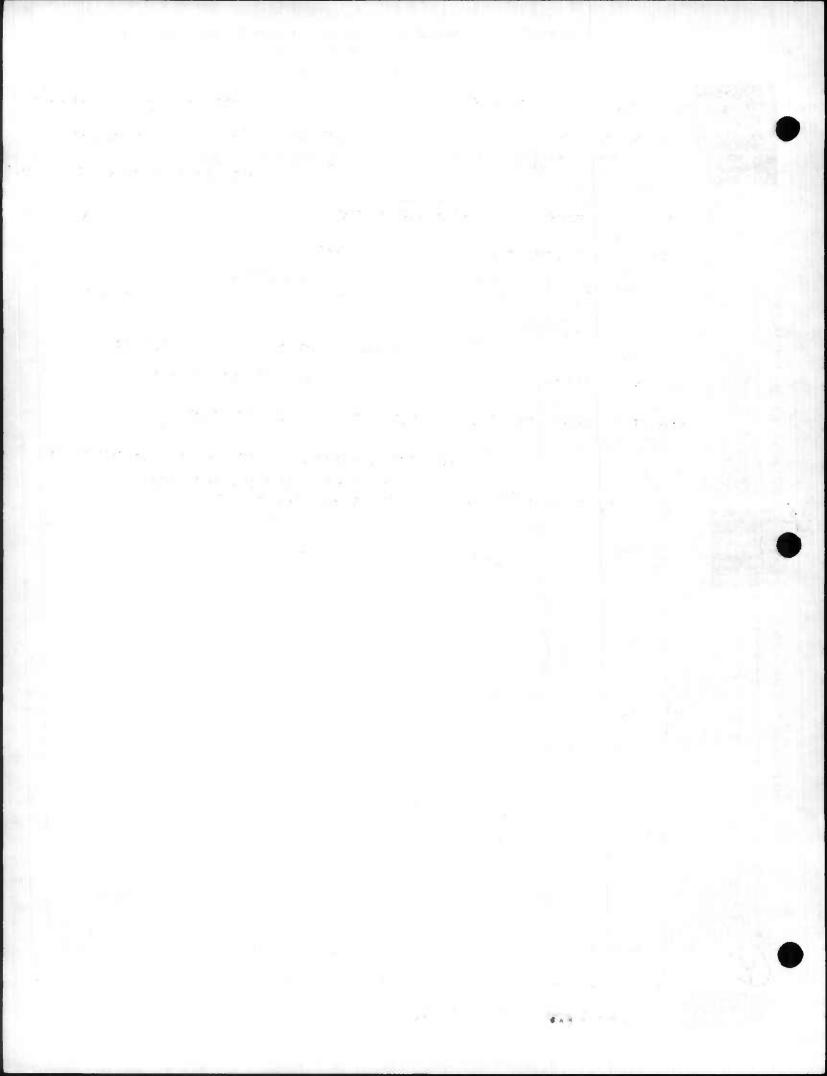
8218 CHHABRA

Wisconsin Ave Bethesda, Md 20214

State Registrar

31. Date filed (Month, Day, Year) FFR 1 9 1998



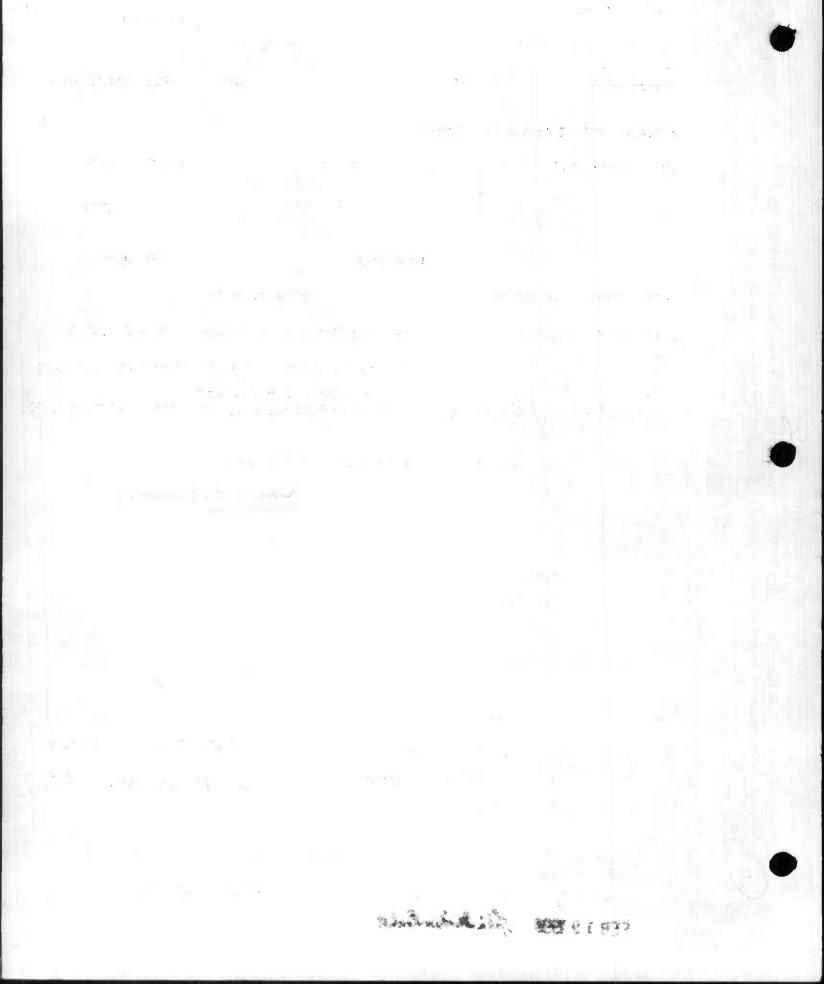


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State Registrar 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Craig (2005211 D.C., 22 SOUTH GREEN STREET, BALTIMORE, MD 21201

31. Dete filed (Month, Dey, Yeer)) 32. Begistrar's Signature

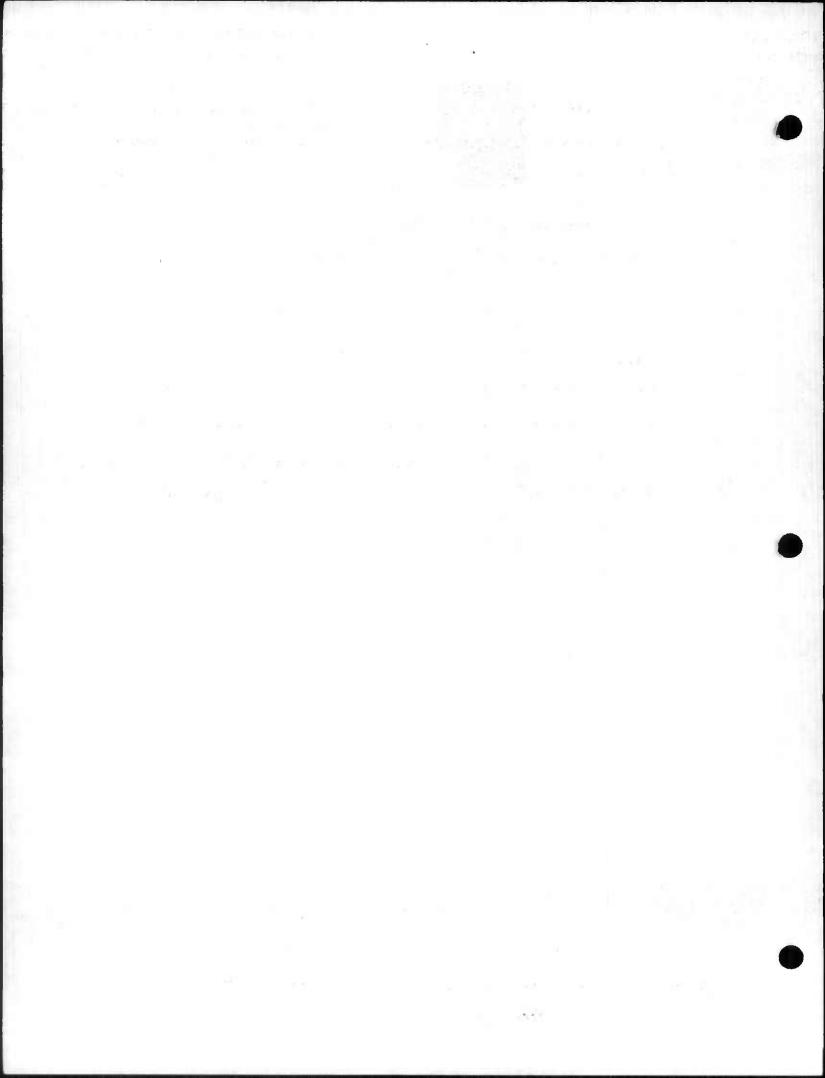


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9467 JUNACK ANNE

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Annie Estella Johnson Smack TEBRUARY 3 1998 2200 /Medicai 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1□M 20F 214-30-9467 Yrs 93 Director 11/09/1904 Oak Hall. VA Usual Residence of Decedent the Maryland 10e Slete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumstic event, the Medical Examiner must be notified at 1 d Yes 2 No Director Worcester Pocomoke City 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? items 23a 503 Tenth Street 21851 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 2 should be filed within 72 hours efter n end Mental Hygiene. Is marked other then "natural", or ite 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: 3X Widowed 4 □ Divorced White Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) 8 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be f nent of Health end Mental Charlie Johnson 2 Laura Trader 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mportant: If item 27 Hilda Bagwell / Daughter-in-law 30326 Calhoun Ave., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 □Burial 2 □ Cremation 3 □ Removal from State 8 Bethany United Methodist Cemetery 6/98 4 ☐ Donation 5 ☐ Other (Specify) Pocomoke City, MD 21. Signeture of Fundral Service Licensee 22. Name and Address of Facility Holloway-Melson Funeral Home Daan 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Appril 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Appril 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata Interval Between Onset and Death **Physician** celed junda accedit /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as e consequence of) Physician/Medical Examiner The jaw requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last physicien and s the burial-tran Due to (or as a consequence of): Box 68760, Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by (1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, þ bete has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of ceuse of death? Be Completed 24a. Was an autopsy performed? 1 Yes 28 No 1 Yes 2 3 No certificete Division of Vital spital or Attending Physician: The hours after death.
Inerel Director: After this certificety filled in by the funeral director, pt 25. Wes cese referred to medicel exeminer? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Menner of Death 28a. Dele of Injury (Month, Day Year) 28c, Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Sulcide 6 Could not be Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours To the Funerel 29a. Certifier TSCertifying Physician: To the best of my knowledge, death occurred el the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated. Medicai completely \$

State Registrar

FEB 1

MCLEAN

30. Name englaggress of person who completed cause of death (Item 23a) (Type, Print)

M.O.

the of prtifier

29b. Signature and

31. Date filed (Month, Day, Year)

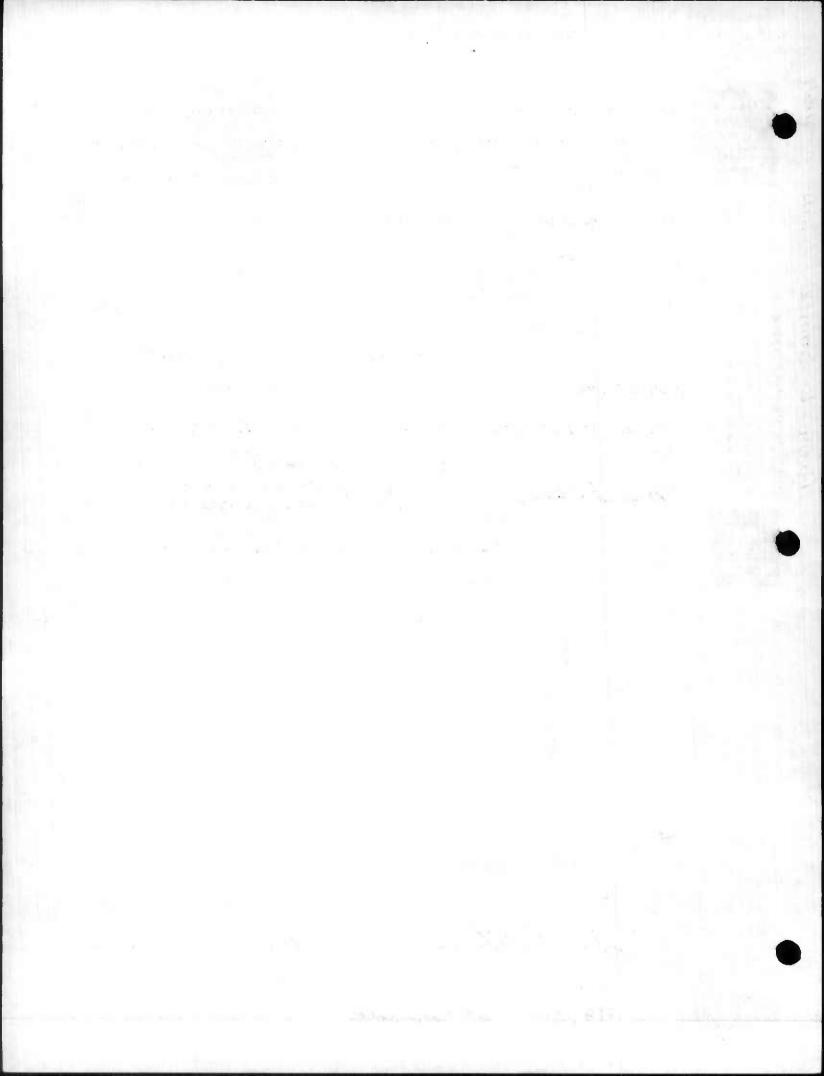


106 MILFORD

29c. License number

D25209

29d. Date signed (Month, Day, Year)



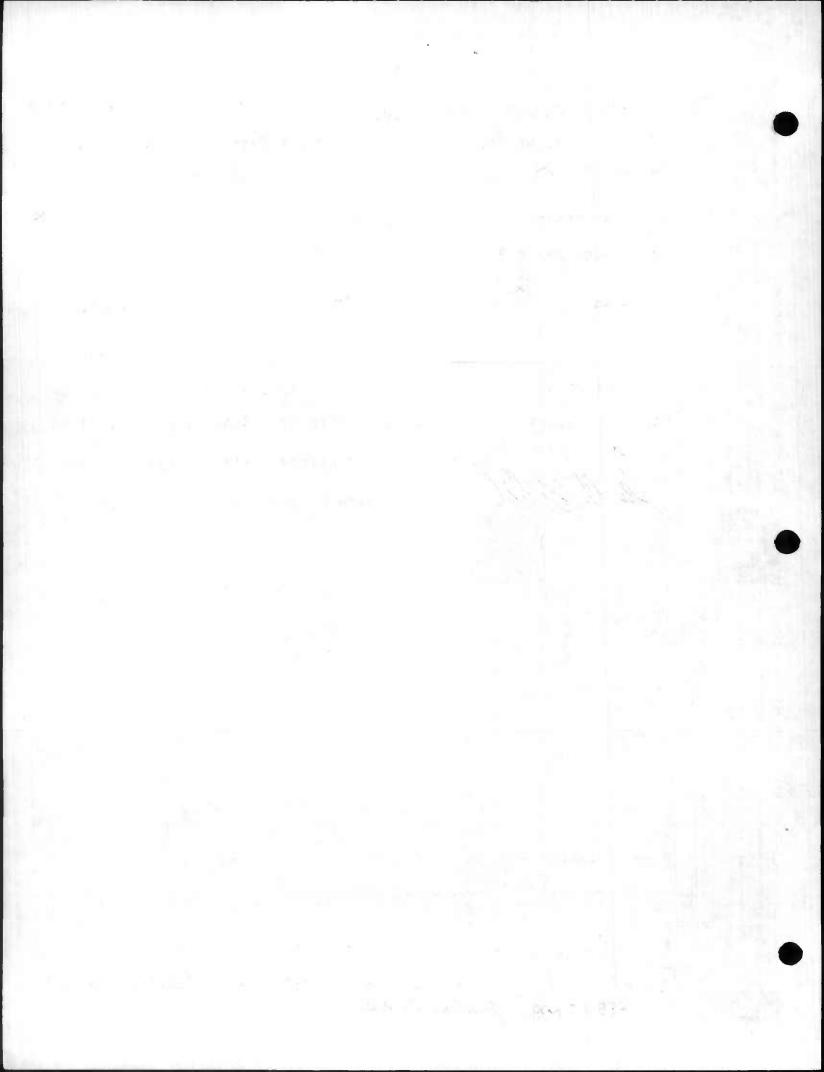
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey **Physician** Month FEBRUARY JONES EDWARD SIMPSON, SR.
4a. Fecility Name (If not institution, give street and number) 11, 199 0900 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 12330 OLD BRIDGE RD. # Under 1 Year If Under 24 Hrs. B. Da Months Deys Hours Min. WORCESTER 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12-18-29 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F 218-24-4523 Yrs. 68 Director MD. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
int: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show ury or other traumatic event, the Madical Examine must be notified as Director MD. WORCESTER 1 Yes 2 No OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12330 OLD BRIDGE RD. 21842 Funeral USA 12. Wes Decedent Ever in IJ,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 MYes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 þ Specify: 3 ☐ Widowed 4 ☑ ivorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) PAINTER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JONES SIMPSON BECKY SIMPSON 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) EDWARD L. SIMPSON 108 N. HILL, MD., 21863 MORRIS ST. SNOW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of important: If It any injury or o 1 ☐ Buriai 2 Scremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation SALISBURY CREMATORY SALISBURY, MD. 22. Name end Address of Facility ULLRICH FUNERAL HOME BERLIN, MD., 23e Mart 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physiclan** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner if or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician end of in by the funeatil director, page 2 should be deteched for use as the bursharshif Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): lipi P.O. Box 68760. Physician/Medicai Due to (or as e consequenca of): Part ti. Other significent conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings evalleble prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 Yes 2 ₩No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only gre) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2₽No Other: 4□ Nursing Home 5 ☐ Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 ANatural 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the ceuse(s) end manner steted. 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 3/4 FRANKLIN- GERLIN, MO 10

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year) FEB 1 7

32. Registrar's Signature



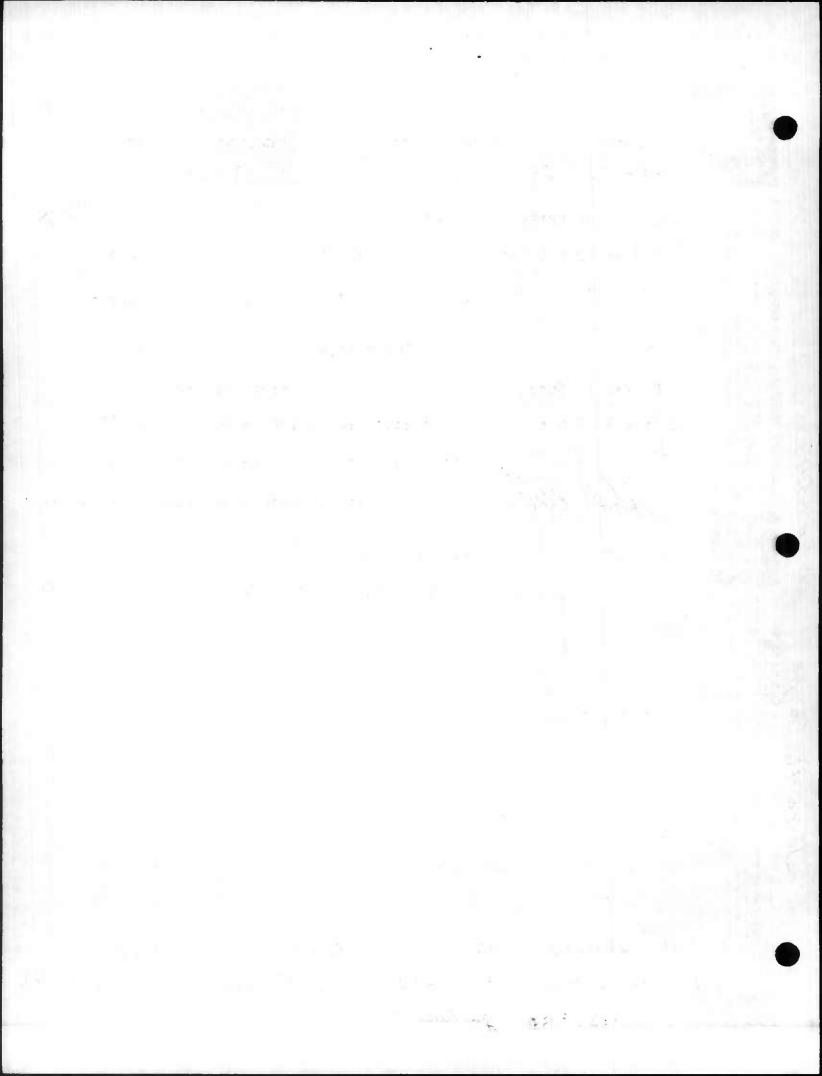
State of Maryland / Department of Health and Mental Hygiene 3 0 7 0

Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** JESSE H. SWOPE Ebruary 17, 1998 tion of Deeth 4c. County of Death /Medicai 4e. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Hours Min. 8 Data of Birth Month Day, Yeer 11 - 27 - 19 5. Sociel Security Number If Under 1 Year 9. Birthplaca (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 10 M 2□ F Months Deys 197-07-3347 Director Usuel Residence of Decedent death with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23s or 28s-f st the Wedical Examiner must be notified MD. WORCESTER BERLIN 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 EAST WIND 21811 DRIVE USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ★Yes 2 □ No If Yes, Giva Wes Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien, permit. Peges 1 and 2 should be filed within 72 hours after Department of Heelih and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinat Bleck, White, etc. 1 Never Merried 2 Married 21215-0020 1 Yas 2 No Specify: Be Completed by SpecifyWHITE Yaar or Dates: WW 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest greda completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) ELECTRICIAN STEEL Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) EDWRAD T. SWOPE ALEANE HILTON 19e. Informent's Neme/Reietlonship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) CLAIRE F. SWOPE EAST WIND DRIVE BERLIN, MD., 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, crematory or other plece) Dete 20c. Location - City or Town, Stata 1 Auriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) SPRINGHILL M.G. SALISBURY, MD. 22. Name end Addrass of Fecility ULLRICH FUNERAL HOME BERLIN, MD., 23a. Part I chiar ha diseese, or complications that causad the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, show, or heart feilure. List only one cause on each line. Approximete Intervel Between Onsat and Deeth **Physician** RESPIRATORY ARREST /Medical Immediate Ceuse (Finel MINS diseese or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Physician/Medical Examiner METASTATIC BLADDER CAKCWOMA MONTHS The law requires that the deeth certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that inliteled events resulting in death) Lest Due to (or es e consequance of): for use es the burial-trar Due to (or es e consequença of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ulnknown PNEUMO THORAX Ď director, page 2 should be 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy certificate hes 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: Certification: To Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this Dete of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Naturel death. To the Hospital or Attendition within 24 hours effer death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.

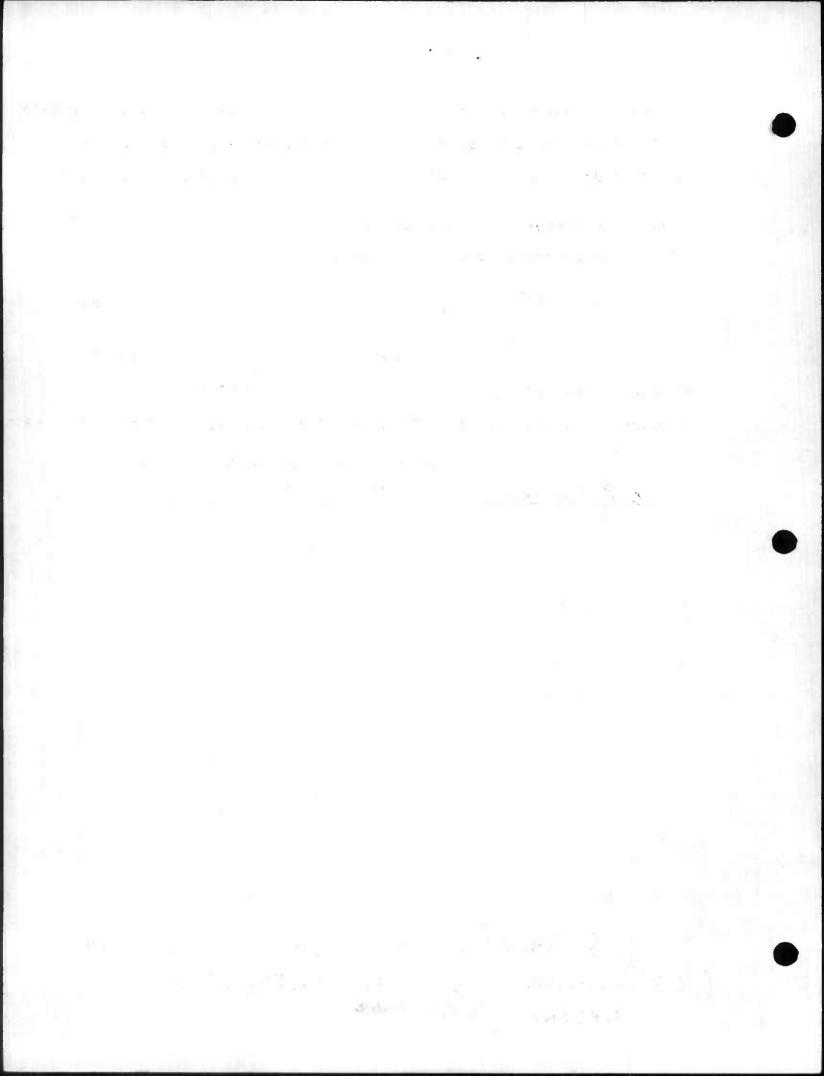
| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end placa, end due to the ceuse(s) end manner stated. Medical 29a. Certities completely (Check only one) 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Snaid M. Cump 100 E CARROLL SALISBURY MP. 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) DUMID M. WOOD MD PRMC 31. Date filed (Month, Day, Yeer) 32. Registrer's Signeture Mulia Davidson-Randall Registrar FEB 1 9 1998

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 0

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician ISADORA** SHIFLETT GRANT FEBRUARY 23,1998 10:35a.m. /Medical 4e. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Pr. Frederick r If Under 24 Hrs. 8. Dete of Bi Calvert 5. Social Sacurity Number If Under 1 Yeer Birthplaca (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1 M 25 F Months Days Hours Min. Yrs Director 577-01-8055 84 1/18/14 Maryland Usuel Residenca of Decadent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at No Yes 2 No Director MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20711 468 Sarah Ann Drive Funeral II.S.A 14. Race - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yas, Give Yaer or Detas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Bieck, Whita, etc. efter 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes X ☐ No Specify: PY 3 Widowed 4 Divorced white Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 12 should be filed w h end Mental Hygier 7 is marked other th homemaker N/A other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Maldan Sumama) Be 70 Isiah Wilson Ida McCready 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Peges 1 end 2 Department of Heelth el Important: if Item 27 is Earl Shiflett 468 Sarah Ann Drive, Lothian, MD 20711 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Steta N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/26/9B Dunkirk, MD So. Mem. Gardens 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Raymond Funeral Home 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiretory arrast, shock, or heart feitura. List only one cause on each line. Dunkirk, MD 20754 Approximate Interval Betwean Onsat and Death **Physician** /Medical Immediate Causa (Final diseesa or condition rasulting in daath) Examiner Examiner ettending physician end for use es the burief-transit certificate be executed Sequentially list conditions, if eny, leeding to immediata cause. Entar Underlying Ceuse (Disasse or injury that initiated asserts. Due to (or es a consequence of) rasarca Box 68760 Physician/Medical that initiated events Due to (or es e consequence of) resulting in deeth) Lest death P.O. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? deteched the 2 1 Yes 2 No 3 Probably 4 Unknown signed t Records, þ 24b. Ware eutopsy findings evellabla prior to page 2 should Completed 24e. Was an autopsy peen completion of cause of death? , hes 2 No certificate 1 Yes 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: Be 25. Was casa raferred to medical examiner? 26. Placa of Death (Check only one) 1 Yes 2 Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 2 this 28c. injury at Work? 27. Mannar of Death 28b. Tima of 28d. Describe how Injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No To the Hospital or Attend within 24 hours efter deatl To the Funeral Director: 3 ☐ Sulcide 6 Could not be datarmined Placa of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 2 4 Homicide 1 Certifying Phyelclan: To the bast of my knowledge, death occurred at the time, deta and place, and due to the cause(s) end mennar as stated.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifian Medicai completely (Check only 29b. Signature and title of certifian 29c. Licansa number 29d. Data signed (Month, Dav. Year) 23 1999 30. Name and address of person who completed cause of geeth (Itam 23e) (Typa, Print) Julie A. Okeefe, M.D., Prince Frederick, Maryland 20678 32. Registraris Signature 31. Date filad (Month, Day, Year) State Jalin Savilson Rardall Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month - awrence Smilh 4:30 PM Februar 22,1998 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death **Examiner** May) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Ballin 5. Social Security Number Medical we cil 7. Age (In yrs. last birthday) 68 Yrs. 6 Sex Birthplece (State or Foreign Country) **Funeral** 1**X**M 2□ F 218 30 2674 Yrs. Director Maryland Usuel Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Calvert Huntingtown 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 151 Plum Point Road 20639 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: white by Specify: 3 Widowed 4 Divorcad "natural", Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any Injury or other traumatic access. Elementery/Secondery (0-12) College (1-4or 5+) farmer/ care taker agriculture 8 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Moody SMith Rosie Beverly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 151 Plum Point Rd. Huntingtown, Maryland Robin SMith- wife 20b. Placa of Disposition (Name of cemetery, crematory or other place) Feb 25 1998

Waters Memorials Cemetery 20e. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Bunai 2 Other (Specify) St. Leonard Maryland 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Rausch Funeral Home Port Republic MD 4405 Broomes Is. Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physiclan** /Medical Immediate Cause (Final Sepsis diseese or condition resulting in death) Examiner Due to (or es e consequence of): Hyourdial Disease physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (ocas a consequence of Records, P.O. Box 68760, chickasis Physician/Medical Due to (or as a consequenca of): for use es arrythmias Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 3 Probably 4 Unknown þ sate hes been signated by page 2 should b 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes ZEINO 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Plece of Death (Check only one) 1 ☐ Yes 2 Hospitei: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Natural 5 Pending after death.

I Director: After din by the fundament 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral DI completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) P11790 ol Dwan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 275. Greene St. UMMS Dept. Medicine Bullimore, MD 21001 arol Swanson 31. Date filed (Month, Day, Year) 32. Registraris Signature State Julia Stavilson Revolate Registrar

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Baltimore,	permit. Pages 1 and 2 Department of Haeith a Important: If Itam 27 is any injury or other tra sncs.		21. Signetura of Funarai Sen		94				ama and Addre		ome, P.A.	Owin	oe Mi	0 20736
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	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After complately filled in by the funer	edical (29e. Certifier 1 Certi (Check only one) 1 Medi	fying Phys cat Examin	ician: To the l er: On tha ba end mann	sis of exer	knowledge, on the knowledge, or the knowledge, o	deeth oco	curred at the tir igetion, in my o	me, dete end ple pinlon, deeth oo	ce, end due to the curred at the time,	cause(s) end m dete and place,	anner as stand due to	nted. the cause(s)
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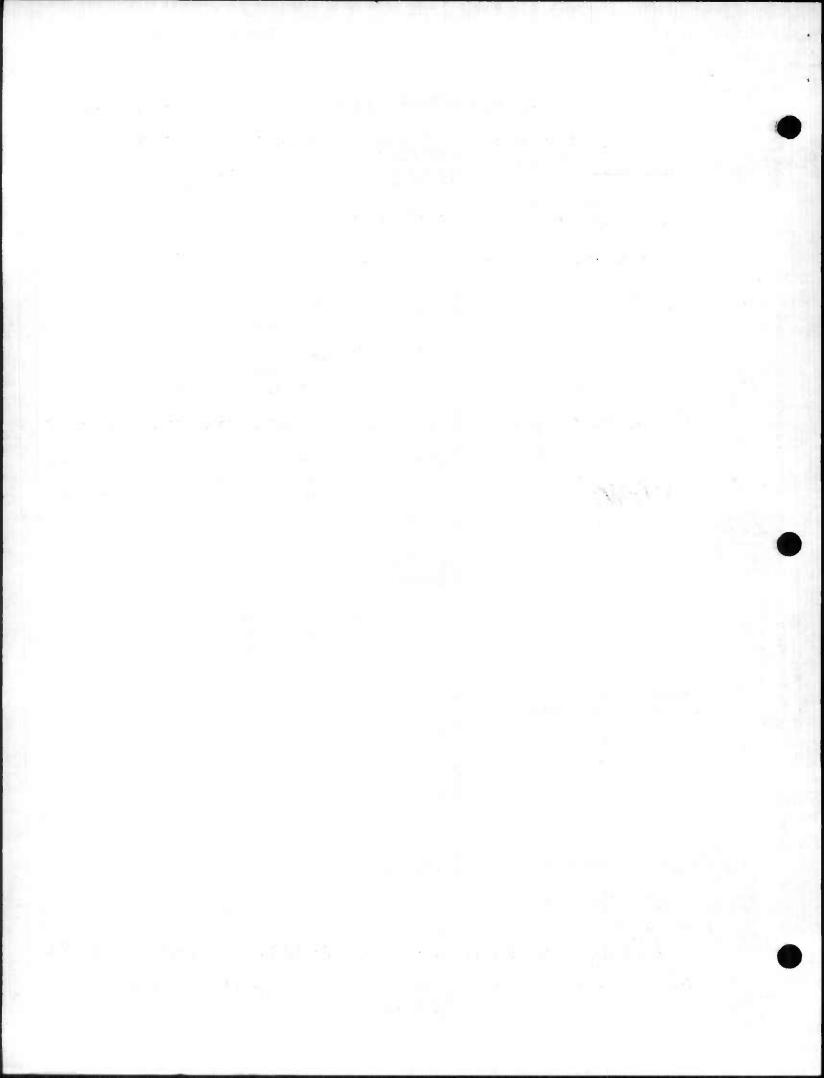
State of Maryland / Department of Health and Mental Hygiene Amended Item #5, Per F.D. 02/26/98, Carroll County, wil Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Dete of Deeth **Physician** Month Year CHRISTINA ELIZA SEIPP 19, 1998 FEB. 12:45 AM /Medical 4a. Fecility Neme (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SYKESVILLE ELDERCARE CENTER SYKESVILLE CARROLL If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Months, Pey, Year) 3 / 1 3 / 1 9 0 1 5. Spring Segurity Mys 1997 7. Aga (In yrs. last birthday) 9. Birthpleca (Stete or Foraign **Funeral** 1□M 20 F MARYLAND 18-54-3379 Yrs. 96 Director Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD. CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Herns 23a 627 HOOK RD. 21157 USA. Funeral 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American indien, Bleck, White, atc. should be filed within 72 hours effer and Mental Hygiena. 1 Yes 2 No If Yes, Give Yaar or Datas: 1 ☐ Nevar Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 🎾 No Specify: Specify: WHITE þ 3 ₩ Widowad 4 Divorced 16a. Decedent's Usuei Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grada completed) Compi Elementery/Secondery (0-12) College (1-4or 5+) 6 HOUSEWIFE HOME MAKER 17. Fethar'e Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) h end Mental h Peges 1 and 2 should be ERNST WOLF SUSIE REESE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) nt of Health e If item 27 is or other tra PAUL L. SEIPP 1769 INVERNESS AVE., BALTIMORE, MD. 21222 20b. Place of Disposition (Nema of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata Department of H Important: If iter any injury or oth once 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) TRINITY LUTHERAN CEM. 2/21/98 WESTMINSTER, MD. 21. Signature of Euperal Servict Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Pert1. Enter the saasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. **Physician** /Medical ASPIRATION PNEUMONIA =5 days Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequença of): The lew requires that the death certificeta be axecuted attending physicien and for use as the buriel-transit Sequentielly ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequenca of): signed by the a Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. ģ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? i certificate has t 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physicien: 25. Wes case referred to medical axeminer? Be 26. Piece of Deeth (Check only one) Other: 45 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 20 No 1 ☐ Inpatient 2 ☐ EFt/Outpatient 3 ☐ DOA this funeral Certification: 27. Menner of Daeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Neturel 2 Accident 5 Pending ours efter deeth.

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filled in by the fu Investigation 1 Yes 2 No 3 Sulcide 6 Could not be 28e. Placa of Injury - At home, ferm, streef, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours of To the Funeral D completely filled Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end manner as meted.

| Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end manner steted. edical 29e. Certifier (Check only one) 29b. SignajOre and title of certifier 29c. Licansa number 29d. Data signed (Month, Dey, Year) 40390 FEBRUARY 19, 1998 AMENDING 14431CIAN 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PANKAJ R. DESAY MD: 5301 OLD COURT ROAD, RANDALLSTOWN, MD 21133 32. Proprietroge Signatura 31. Dete filed (Month, Dey, Year) State FEB 2 0 1998

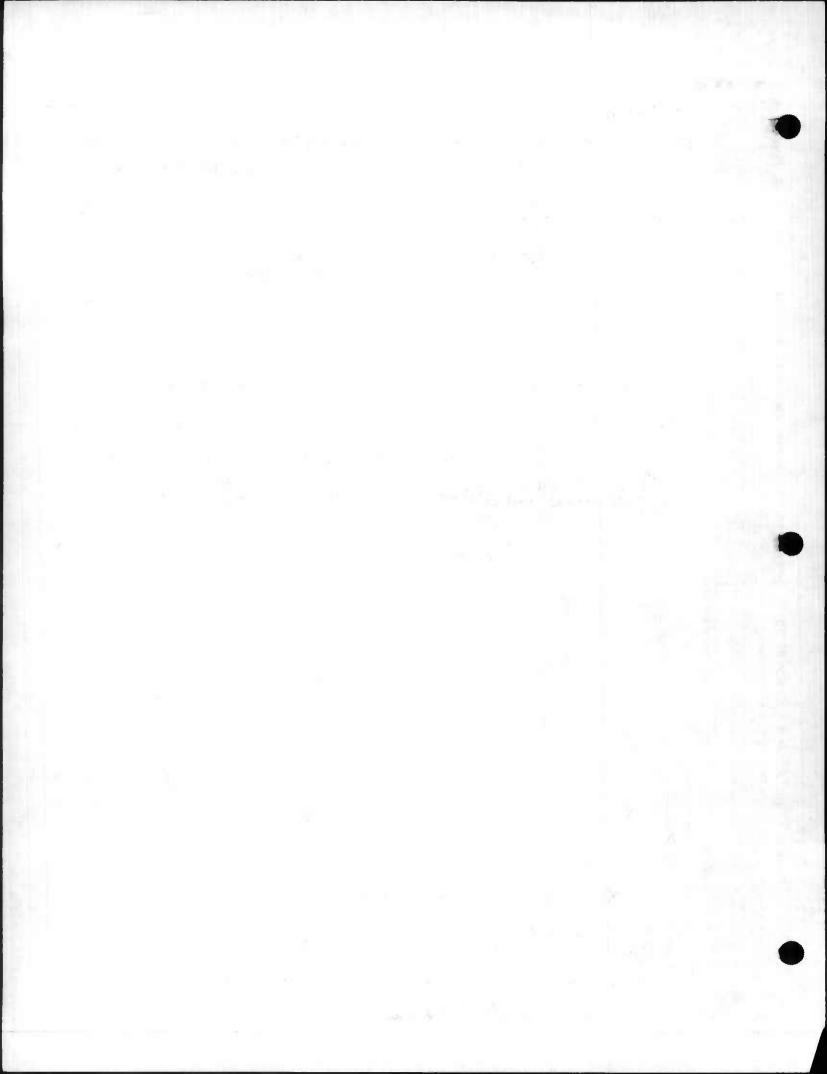
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Registrar



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Funera Directo		5. Social Sacurity Number 6. Se 214-32-2642 10 Usual Rasidance of Decedant	7	74 Yrs.	Months Days		8. Data of Birth (Month, Day, Apr. 10,	1923	9. Birthplaca Country) Mar y	(Stata or Foreign
ryland how		10a. Stata 10b. County		City, Town or Lo	ocation				10d. I	Inside City Limits
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with the	Pie	10e. Street and Numbar	4-4 610		10f. Zip Coda	21702	10	g. Citizan of W		
Jeath The 23	Funeral	1421 Taney Ave.,	12. Was Dacedant Evar in	n U.S. 13.	Was Decedent of	21702 Hispenic Origin? (S	pecify Yas or No-		S.A.	ndien.
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Peges nent of h		1 Burial 2 Cramation 3 F 4 Donation 5 Other (Spacify)	Ramoval from Stata		matory or other pl i11 Ceme		2/21/98 n			
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filtrete be executed 3 physician and ss the bunel-transit	Examiner	Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying	b. — Dua to	o (or as a consac	quance of):					
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that the dead by the	hysi	Part II. Other significant conditions cor	ntributing to death but not	rasulting In tha u	ndariying ceusa g	ivan in Part I.	23b. Did tob	1		cause of death
es tha es tha be de	by P							,,,,,,,		
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= F and							1□ Ya	s 2 No	1 🗆 Ye	s 2 No
Physician: The this certificate ral director, peg	o Be	25. Was casa rafarred to medicel axaminar?	lospital:		_ [0		th (Check only one			
a this	-	1 Yas 2 No 27. Mannar of Death 1 Natural 5 Panding 2 Accident invastigation	1 ☐ Inpatient 2 28a. Data of Injury (Month, Day Year	28b. Tima o	f 28c. Inju	ury et ork?	4 Nursing Homa 5 Hasidence 6 Dothar (Specify)			
Hospital or Attending P 44 hours efter death. Funeral Director: After it	Certification:	3 Sulcide 6 Could not be detarmined	28a. Place of Injury - A building, atc. (Spa							uta Number,
To the Hospital or Att within 24 hours efter of To the Funeral Direct completely filled in by	edicai C	29a. Cartifiar (Check only one) Cartifying Physical Examination	sician: To the bast of my k nar: On the basis of exam and mannar stated.	knowledga, daati ination and/or In	n occurred at tha t vastigation, in my	tima, data and place opinion, daath occu	, and dua to tha car rred et tha tima, da	usa(s) and man ta and place, a	nar as stated nd dua to tha	causa(s)
To th To th comp	Me	29b. Signatura end titla of certifler	4			nse number	29	d. Data signed	(Month, Day,	Year)
		Jans 1).	Insm.		D	21944		2/20	198	
		30. Name and address of person who co James S. Grisson				odowa sta ili	MD 21701	•		
	ate	31. Data filed (Month, Day, Year)	32. Registrar's Sig	. 9th St		ederick, l	21/01 עוי			
ى Regist		EED 2 0.1	ago Jalia	welearRas	de tt					

DHMH 16 Rev 6/95



	Ob. Per F.H. P.G.C. 2-23-98 cr Certificate of Death 1. Decedent's Neme (First, Middle, Last)	2. Dete of De		3. Time of Death
hysician /Medical	VIOLA E. TAIT	Februar		98 ^{eer} 10:47 PM
xaminer		or Location of Dear		
_	WASHINGTON ADVENTIST HOSPITAL Takoma 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Yaar If Under 24			gomery
neral ector		Hrs. 8. Dete of Bi Min. Month D	1927	9. Birthplece (State or Foreign Jamaica, W.I.
1	10a. State 10b. County 10c. City, Town or Location		-	10d. Insida City Limits
Examiner must be notified at by Funeral Director	D.C. N/A Washington			1⊠ Yes 2□ No
Director	10e. Street and Number 10f. Zip Code		10g. Citizen of V	Whet Country?
le le	12 Channing Street N.E. 20002		Jamaci	.an
by Funeral	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever In U,S. Armed Forces? 1 Yes, Sive Year or Detes: 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexicen, P 1 Yes, Sive Year or Detes:	? (Specify Yas or No uerto Rican, etc.)		e - Amarican Indien, ck, White, etc.
pet	15. Decedent's Education 16e. Decedent's Usuel Occupation			usiness/Industry
Be Completed	(Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) (Give kind of work done during most of life. DO NOT use retired)	working		
So	9th Housekeeping		Holida	
		Neme (First, Middle na Bailey	, Meiden Sumen	10)
other traumetic	19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number of		or City or Tour	State Zin Code 20784
	Dawn Wilson - Daughter 7601 Fontain Bleau D			
				City or Town, Steta
	20a. Method of Disposition 1XD Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify)	H111 cy 2-21	Suitland	, MD
any injury or other tr once.	21. Signature of Funeral Sarvice Licensee 22. Name and Addrass of Facility Marshall's Fun	1 IIO	Total	
8.8	Marshall 4217 9th Stree			DC 20011
	23a. Full . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carbook, or hear feilure. List only one ceuse on each line.	diac or respiretory	errast,	Approximeta Intervei Between
ian				Onset end Death
licai iner	Immediete Ceuse (Final diseese or condition e. Cardiac Arrest			10 minutes
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Examiner	Coronary Artery Disease			4 yrs.
the burial-transit	Sequentielly list conditions, if eny, leeding to immediate seuse. Enter Underlying Diabetes Mellitus			unknown
odicai	Cause (Disease or Injury that Interest in the Initiated events resulting in deeth) Lest Due to (or es a consequence of):			ulikilowii
= •	d.			
by Physician/M	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b Did	tobacco use co	ntributa to the cause of death?
be detached to by Physic				3 Probably 4 Unknown
by E	Multiple cerebro vascular accident	_		
2 should pleted		24e. Wes	s an autopsy ormed?	24b. Were autopsy findings available prior to completion of causa of death?
Com		10	Yes 2⊠No	1 ☐ Yes 2 ◯ No
Be Be	exeminer?	Deeth (Check only	one)	
를 라		g Home 5 Res		., ,,
led in by the funera Certification:	1 Neturel 5 Pending (Month, Day Year) Injury Work?	28d. Describe	how Injury occur	red
d in by the fu Sertification	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office	28f. Location	(Street end Numb	per or Rural Route Number,
d in	4 Homicide building, etc. (Specify)	City or To	wn, Stete)	
completely filled in Medical Cert	29a. Certifier (Check only one) Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end p 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death of end manner stated.	ece, end due to the courred et the time,	ceuse(s) end me dete end plece,	enner as steted. end due to the ceuse(s)
M	29b. Signeture end title of certifier 29c. License number		29d. Date signe	d (Month, Day, Yaar)
	Auguster handel 11707		Febru	ary 10, 1998
	Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)			
	Susan Leibenhaut, M.D. 110 Irving Street N.W., W. 32 Registrer's Signeture	ashington	, DC 200	10

whitehall press

nysician		1. Decedent's Neme (First, Mid MYRTLE		JRRENT]	INF						2. Dete of I		Day,	1 086		of Death
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Kallillei		7816 KLOVSTAI											PRINCE GEORGE		S	
neral ector	2	5. Social Security Number 246–44–6486	6. Sex 1□	M 2 7 F		s. lest birthday) 75 Yrs.	If Unde Months	er 1 Yeer Deys	If Under Hours	24 Hrs. Min.					Birthplece (Stete or Fo	
		Usuel Residence of Decedent 10e. State 10b. Count	ty		10c. C	City, Town or Lo	ocation							10	Od. Inside	City Limits
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To Be	5	JOEL HARRIS	e, Last)							NNIE	GARR		den Sumen	ne)		
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e)	\vdash	21. Signature of Funerel Service							ss of Fecili		10/30	DKI	PHIMO	OD, FL	AKIL	AND
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month LORENCE FEBRUARY 14 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) MONTGOMERY HOSPITAL TAKOMA PARK WASHINGTON ADVENTIST 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) 1□ M 2□ F 578 26 5472 Yrs. OCT 16,1919 SOUTH Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits WASHINGTON, D.C. 1 Yes 2 No NONE D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20017 USA 2529 14th STREET N.E. 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2 🔯 No If Yes, Give 1 Navar Marriad 2 Married 1 ☐ Yas Z♥ No Specify: Specify: BLACK t Yes, Give Yaar or Data*s*: 3 -Widowed 4 Divorcad 15. Dacadent's Education (Specify only highast grada complated) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) RESTAURANT 7th COOK 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) ISABELLA ALEXANDER ROBERT A. WILLIAMS 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19e. Informant's Nama/Ralationship (Typa, Pnint) 1024 KING TREE DR. MITCELLVILLE , MD PATRICIA TUTT (NIECE) 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) FEB20, 1998 SUITLAND, MD WASHINGTON NATIONAL 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility RALPH WILLIAMS FUNERAL SVC 23a. Part1. Entar tha disassa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only one ceuse on eech line. Approximata Interval Batwaan Onset and Deeth Hypotensicn Bysis / neh Immediete Cause (Final disaese or condition rasulting in daath) Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Drenmonin 1 Yes 2 No 3 Probably 4 Unknown STAIL 24b. Wara autopsy findings avelleble prior to complation of causa of daath? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Wes case rafarred to medical axaminar? 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 27. Menner of Death 28c. Injury at Work? 1 Naturel 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datermined 3 Sulcida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

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funaral director

Physician

/Medical

Examiner

Director

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Funeral

Director

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permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylen Depertment of Haalth end Mantal Hygiana. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Example must be notified at once.

Physician /Medical

Examiner

Examiner

Physician/Medicai

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P.O. Box 68760, Division of Vital Records, or Attending Physician: eftar death. Hospital 24 hours e Funeral D

Registrar

Certifying Physician: To the bast of my knowledge, death occurred at the time, deta end piece, and due to the causa(s) and manner as stated.

Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and piece, and due to the causa(s) and manner stated. 29a. Certifian (Check only one) 29b. Signatura and titla of certified 29d. Data signad (Month, Day, Year) 29c. Licansa number

D 39 372

1998

30. Name and address of person who compreted cause of beath (Item 231) Atype, From) 1 - 344 UNIVEYSITY B(U)

Suit 324

31. Data fillad (Month, Day, Yaar)

32. Registrar's Signatura

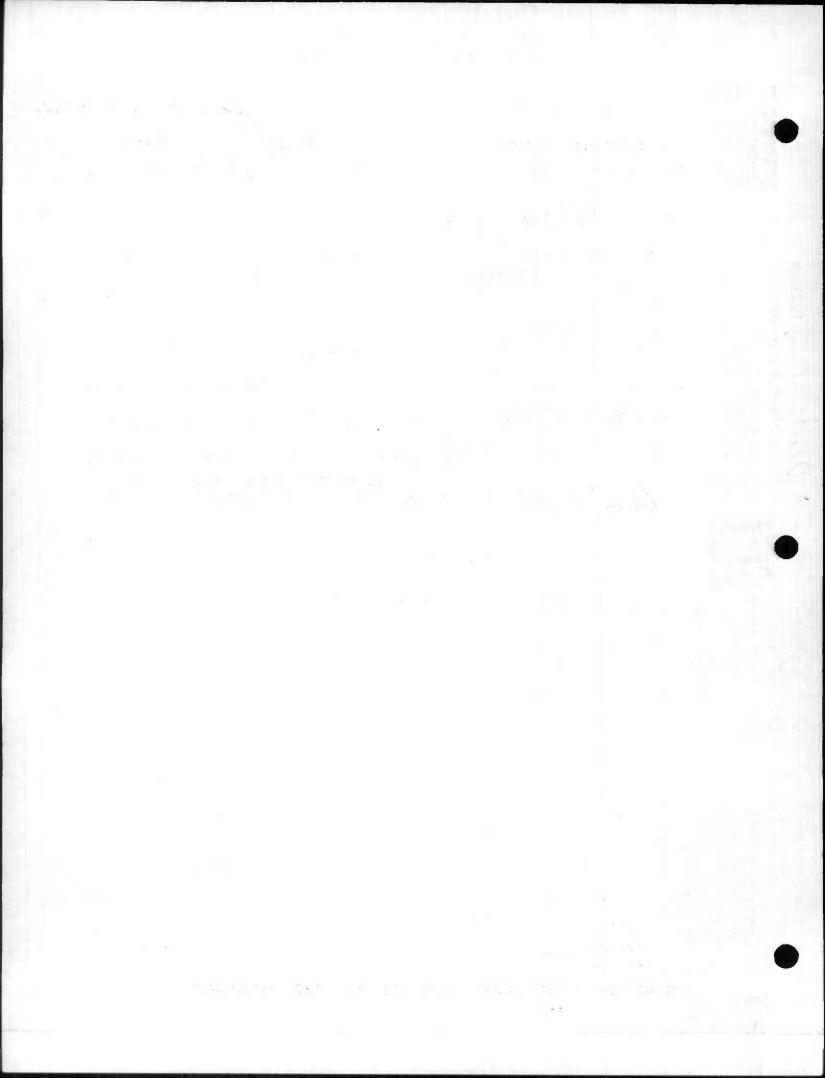
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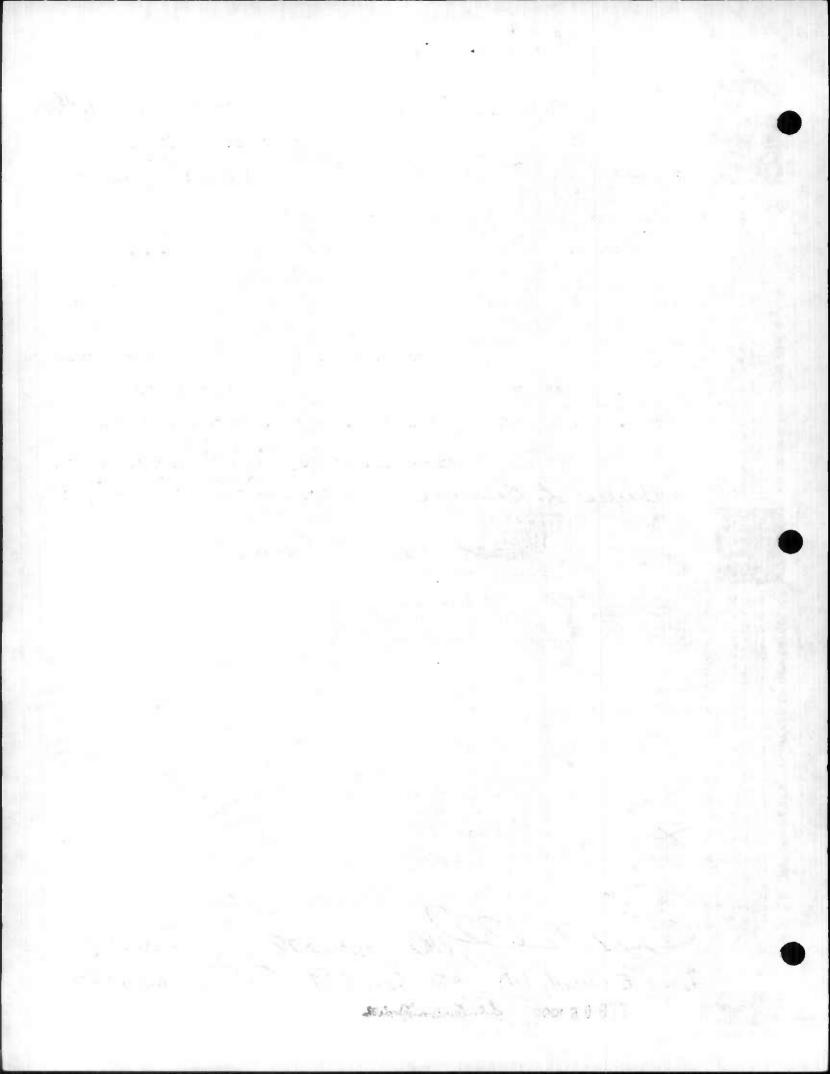
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** Walter Russell Tayman 4:49 P.M. February 20 1998 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Physicians Memorial Hospital La Plata Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Day Year) | 1 Under 1 Year | 1 Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Year | 1 Under 1 Y Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** 579-16-7195 Yrs Director Usual Rasidence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Indian Head 1 ☐ Yes 2 No Charles r than "natural", or items 23s or 28s-f si the Medical Examiner must be notified Director MD 10f. Zip Coda 10g. Citizen of What Country? 10a. Street end Number 2725 Butterfly Place 20640 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? ↑CPYes 2 □ No If Yes, Give Yeer or Dates: WW II 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 □ Never Married 2 □ Married Specify: White 1 Yes 2 No Specify: þ 30 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Coltaga (1-4or 5+) Grocery Produce Manager 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Clarence W. Tayman Mary Myrtle Dement Tayman 19a. Informant's Name/Ralationship (Type, Print)
James R. Tayman/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 216 Marsh Quay Chesapeake, VA 23320 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 8 Trinity Mem. Gardens 2/23/98 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Licansee 22 AREHART ECHOLS FUNERAL HOME, PA MO0945 P.O. Box 567 LaPlata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting In death) /Medical **Examiner** Examiner attending physician end for use as the burial-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disaase or Injury Due to (or as a consequence of) requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, Physician/Medicai thet initiated evants resulting in death) Last Due to (or as a consequence of): signed by the a Part II. Other stanificent conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown à 24b. Were autopsy findings evallable prior to 24a. Was an autopsy performed? completion of cause of death? page 2 s certificate hes 1 Yes 2 No 1 Yes 2 No Attending Physician: 25. Was case referred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Home 5 PResidence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 1 (X)Naturat 5 Panding e Hospital or Attending n 24 hours efter death. e Funeral Director: Afte 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be dataminad 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 29a. Cartifier 1 Certifying Physicien: To tha best of my knowledga, daath occurred at the time, date and place, and dua to tha causa(s) and manner as stated To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature and the of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Daniel Howell, MD 11345 Pembrooke Square, Suite 104, Waldorf, Maryland 20603 32 Aggistrar's Signature State

Registrar



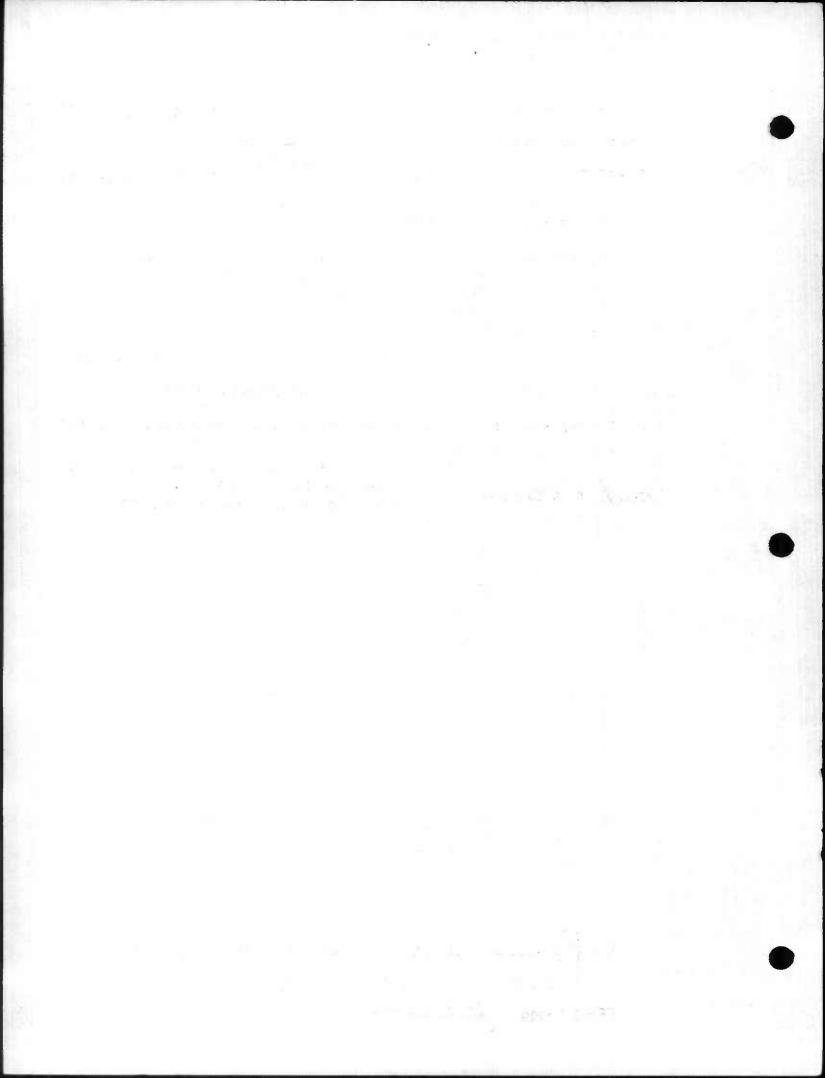
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth Alvey **Physician** Month DORIS PATRICIA TRIBLE JANUARY /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BREEZEWAY LANE PINES OCEAN WORCESTER 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) 1928 9. Birthpiece (State or Foreign Country) **Funerai** Deys Hours 1□M 2XF 69 Yrs Director 579-34-8315 August 12 Maryland the Maryland 10e State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Maryland Worcester Ocean Pines 1 Yes 2 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? #4 Breezeway Lane 21811 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ⊆ ☑ No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or Noif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Biack, White, etc. 11. Maritel Status permit. Peges 1 and 2 should be filed within 72 hours after to Department of Healin and Mental Hygiene. Important: If flem 27 is marked other than "natural", or iten any injury or other traumetr. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ White 3 Widowed 4 □ Divorced Completed 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 12th Registered Nurse Physicians Office 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be William Thomas Alvey Mary Virginia Brown 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Faye A. Zidek (Sister) 15500 Dr. Bowen Rd. Brandywine, Md 20613 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cametery, crematory or other plece) 20c. Location - City or Town, Stete Feb. 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Resurrection Cemetery 1998 Clinton, Maryland 21. Signeture of Funerel Servica Licansee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medicai Immediete Ceuse (Final diseese or condition resulting in death) **Examiner** Due to (or es e consequence ot) Examiner The lew requires that the death certificate be executed buriel-transit Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequenca of): attending physician for use es the burie P.O. Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 2 No 3 Probably 4 Unknown 1 Yee Records, ò cate has been significant categories categor Be Completed 24b. Were eutopsy findings evelleble prior to completion of cause ot deeth? 24e. Wes en eutopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certifica stell filled in by the funeral director, p 25. Wes case referred to medical exeminers 26. Plece of Deeth (Check only one) Hospitel: 1 inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 2DINO Certification: To 1 Yes ■ Residence 6 Other (Specify) 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Naturei 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 29a. Certifier Medical Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted. 2 Medical Examiner: On the basis of examinetion end menner steted. nd/or investigetion, in my oplnion, deeth occurred at the time, date and place, and due to the cause(s) 295. Signature and bile of certifie 29c. License number 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 145E M acally 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State FEB 0 6 1998 Alin Navidson Registrar



State of Maryland / Department of Health and Mental Hygiene 8

		2.1					ificate o	f Death	F	leg. No.	0700	0
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	/Medi	cal	Lee Atwell					4 01 5	02	04	199810:	54 PM
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	Funeral Director		5. Sociel Sacurity Number 230-18-0765	6. Sex M D M 2□ F	7. Age (In yrs. last	t birthdey) 4 Yrs.	If Under 1 Ye Months Day		8. Deta of Birth (Month, Day 1/30/	, Yeer) 1924	9. Birthplace (State Country) Virgini	
	and *		Usual Rasidance of Dacedent 10a. Stata 10b. Coun	ty	10c. City, T	Town or Loca	ation				10d Inside	City Limits
	rith the Marylan or 28a-f show	ctor		ester		omoke						as 2 No
	death with the Maryland me 23a or 28a-f show name to notif at	Funeral Director	10e. Street and Number 2516 Worcest	er Hwy.			10f. Zip Code 2185			10g. Citizen of N		
020	urs after death w al', or items 23a Examiner naut	by	11. Manital Status 1 Naver Merried 2 Ma 3 Widowed 4 Divorce	Armed Fo	edent Ever in U,S. rcas? 2 Do va 1942— atas 947		as Decedent of Yas, specify C	f Hispanic Origin? (Suben, Mexicen, Puer lo Specify:	Specify Yes or No- to Ricen, atc.)	14. Rac Biad Specify	e - Americen indian, ck, Whita, atc.	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMENDED #16b/19b, E.P., WORCESTER State of Maryland / Department of Health and Mental Hygiene \ \(\text{\text{\$\gamma\$}} \) COUNTY Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yee **Physician** John Henry Taylor 02 98 2 PM /Medical 14 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 301 S. Church Street Snow Hill Worcester 5. Social Security Number if Under 1 Yeer If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) July 2,1931 Birthpiece (State or Foreign Country) **Funeral** 10XM 2□ F 217-28-3431 Yrs Director 66 Maryland Usuel Residence of Decedent with the Maryland 10e. Stete 10c. City, Town or Location 10b. County 10d, Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelib and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show say injury or other traumatic event, the Marian Experies man be notified as any injury or other traumatic event, the Marian Experies. 1 ☐ Yes 2 ☐ No Directo Worcester Snow Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 301 S. Church Street 21863 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritei Stetus 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1X Never Married 2☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Lumber Company Elementery/Secondery (0-12) College (1-4or 5+) 9th Laborer Milton Logs Laws 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Linwood Taylor EdnaMannel 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1010 Schoolfield St. Spey Hill, Maryland 21811 Mary Wright 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Buriel 2 Cremetion 3 Removel from State 2/20/98 Girdletree, MD Coolspring Cemetery 4 Donetion 5 ☐ Other (Specify) 21. Signerare of Funerei Service Lyange 22. Name and Address of Facility BENNIS any In HUY JAISBUR 23e. Pertil. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervei Betw **Physician** Immediete Cause (Finel diseese or condition resulting in death) /Medical e ASCVD FUERAL Examiner Due to (or es e consequence of): Examiner physician and s the buriel-transit thet the death cartificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 83 USB 0 signed by the et id be detached for Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 40 Unknown 1 ☐ Yee 2 ☐ No þ 24b. Were eutopsy findings evallable prior to completion of cause of deeth? 24e. Wes an eutopsy performed? Completed peeu hes 1 ☐ Yes 2 X No 1 Yes 2 No al or Attending Physician: T s after deeth. I Director: After this certifical ed in by the funeral director, p 25. Wes case referred to medical exeminer? Be 28. Piace of Deeth (Check only one) Hospitel: 1 No 2 No ٩

Division of Vital Records, P.O. Box 68760, To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending 2 ☐ Accident investigetion 1 Yes 2 No 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

203 SNOW ST. SNOWHER, MD. 21863

State Registrar

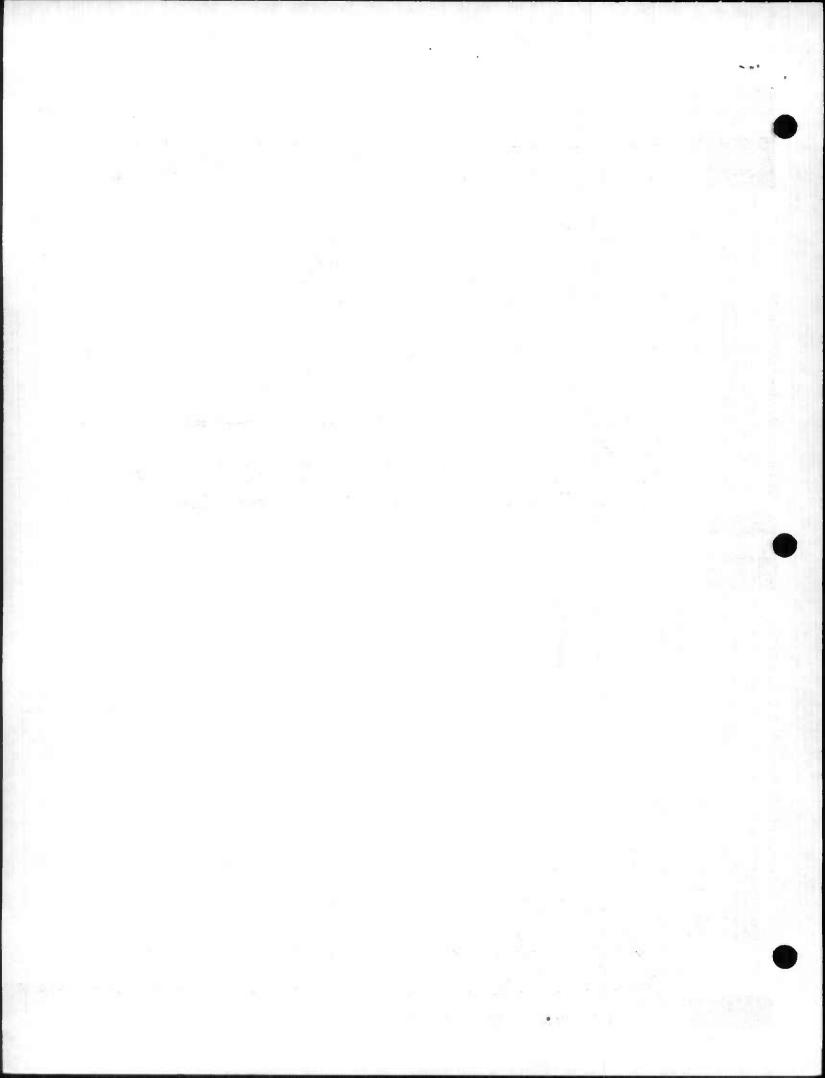
Certification:

Medical

31. Dete filed (Month, Dey, Year)

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6WWORTH 32. Registrer's Signeture Likia Davidson-Randall



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Maryland	2 sho and is me		19e. Informent's Name/Reletionship (T)	ype, Print)	19b. Mellin	g Address (Street	t end Number or Run	al Route Numb	er, City or Town, S	State, Zip Code)
e,	s 1 and 2 should be filed f Health and Mentel Hyg tem 27 is marked other other traumatic event,	5	WILFRED USHER (20e. Method of Disposition	SON)	Place of Dispos	5402 S	EAN DRIVE	FREDE		G, VA. 22407 City or Town, Stete
mor	ages ent of it: if its		1 ☑ Burial 2 ☐ Cremetion 3 ☐ F	Removel from State	cemetery, crem	oLN CEME		3/98	BRENTWOO	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra		21. Signature of Funerel Service Licens			Name end Addre	JOHN T. RI	HINES C	0., INC.	7
			23e. Papi. Enter the disease, or comp	licetions that caused the dee	eth. Do not ente		3030 12TH ing, such es cerdiac o			Approximete interval Between
	Physician		shock, or heert feilura. List only o	ne causa on aach line.	0					Onset and Deeth
	/Medical Examiner		Immediate Cause (Finel disease or condition resulting In deeth)	θ	Ker	al Fail	ure			weeks
		P	resulting in deethy		(or es e consegu	uence of):	OF Pros.	75+0		40000
	d d ansit	Examiner	Sequentially list anaditions	b. Metasta	or es e consequ	1	P (10)	19/6		/ ears
o,	icate be executed physician and s the buriel-transit	Exa	Sequentielly list conditions, if eny, leeding to immediate ceusa. Entar Underlying Ceuse (Disease or injury	500101	0.00000000	301100 017.				
68760,	sate b	dical	thet initiated events resulting in death) Lest	Due to (or es e consequ	ience of):				
	5 0 6	w		d						
Box	death e atten	cian	Doe II Other classificant and distance		41 1 4	1-1-1-1		l and Bill		
P.O.	by the	Physician/M	Pert II. Other significant conditions con	nthbuting to death but not re	sulting in the un	denying ceuse gi	ven in Pert I.	23b. Did		tributa to the cause of death? 3 Probably 4 Unknown
	8 58	ру Р								
Records,	aw requires been so	Completed							an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of deeth?
	The cate h	Con						10	Yes 2 No	1 ☐ Yes 2 ☐ No
Vital	Physician: The this certificate ral director, pag	o Be	25. Wes cese referred to madical examiner?	Hospital:	/	_ Ott	26. Plece of Deetl			
o	fing Physician: The ling. After this certificate he funeral director, page	-	1 Yes 2 No 27. Manner of Deeth	28e. Dete of Injury	ZER/Outpatient 28b. Time of	3□ DOA 28c. Inju	4 LI Nursing Ho		dence 6 Othe	
ion	Attending or death.	ation	1 ☑ Netural 5 ☐ Pending Investigation	(Month, Dey Year)	Injury		rk?]Yes 2 ☐ No			
Division	al or Atte s after de il Directo ed in by th	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Plece of Injury - At a building, etc. (Special Control of the	nome, farm, stre	et, fectory, office		28f. Location (City or To		or Aural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Exami	elcian: To the best of my knoner: On the basis of examinating and menner stated.	owledge, deeth ation and/or inv	occurred et the til astigetion, in my o	me, dete end place, opinion, daeth occurr	end due to the ed at tha tima,	ceuse(s) and mer data and place, a	nner es steted. nd dua to the ceuse(s)
	To the To the Complex	M	29b. Signeture end title of certifier	MA		29c. Licens	se number	/	29d. Date signed	(Month, Day, Year) -> 14,1998
1	5/		30. Neme end add ear of person who co	omplated causa of death (Ite		Vew Han	mp shire A	ve, Si	lver Sprin	9/18/209
	Sta Registr	85HIII	\$1. Data filed (Month, Dey, Year) FEB 2 0 1998	32. Registrer's Sign	eture		V	,	55	,
			1 6 0 1330	The second section of the second second	- THEOLAN					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 98 07088

							Ce	rtificate of	f Death	1		Reg. No.		01000	
			1. Decedant's Nama (First, Middla, La	ist)						2. Deta of De Month	eath Day	Van	3. Time of Death	
	Physic /Medi		Elise '	Vartabe	dian						Februa	ry 15,	Yaar 1998	12:50 pm	
	Exami		4a. Facility Nama (If no	ot institution, giv	a street and nu	mber)			4b. City, To	own, or L	ocation of Deat		of Death	1	
	=		Larkin Cha	ase Nur	sing Ho	me			Bow	ie		Princ	ce Ge	orge's	
1	Funeral		5. Sociel Sacurity Num			7. Aga (In yrs. I	ast birthdey)	If Undar 1 Yea	r If Under	24 Hrs.	8. Data of Bi	rth		placa (Stata or Foraign	
1	Director		103-07-446	6	I□M 2\ F	97	Yrs.	Months Day	s Hours	Min.	(Month, Da	4, 1900	Ru 1 o	ntry)	
Н			Usual Rasidenca of De							J	верс.	+, 1900	Dulg	arta	
	ylan		10a. Stata 1	0b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
	Mary Mary	to	Maryland 1	Prince (George !	s Bow	7ie							1 X Yas 2 No	
	the roun	9	10e. Street end Numb		00180	B BO	10	10f. Zip Coda				10g. Citizen of	Whet Cou	ntry?	
	23a or	ā	12006 Ro	ckledge	Drive			207	15			U.S.A			
	eath	Funeral Directo	11. Marital Status	cittedge	_	edent Ever In U.S	5 13 1			rlain? (Sn	acify Yes or No		14. Race - Amarican Indian.		
	items items	E I	1 Nevar Married	2∏ Married	Armed Fo	orcas?		Was Decedant of f Yas, specify Cu	ben, Maxica	n, Puarto	Rican, atc.)	Ble	ck, Whita,		
21215-0020	72 hours after death with the Maryland natural', or items 23s or 28s-f show dical Examinar must be notified at	by	3 Widowed 4 (If Yas, Gi	va	1	1 ☐ Yas 2 ☒ No	o Specify	:		Specif	y: W	hite	
ö	hou	8		5. Decedant's E		1	16a Dace	dent's Usuel Occi	unation			16b. Kind of B	usiness/in	dustry	
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212	within ene. then	E	Elementary/Second	ery (0-12)	College (1-4or 5+)		ewife	,			Own I	Tome		
	filed withi Hygiene. rther than		17. Father's Nama (Fir	rst, Middla, Last)				18. Moth	ar's Nam	a (First, Middla	. Meiden Sumer			
lan	Mentel Mentel Merked o	To Be	Ohan Vaha	an Sahai	rian				Mole	ruhy	Garabe	dian			
Maryland	2 should and Men is marke	F	19a. Informant's Name				19h Mailir	ng Addrass (Strai					State 7ii	Code)	
Z			Joseph O.			Son		Rockled						0715	
9	Hee Hee		20a. Mathod of Dispos		ıran -	20b. Pl	ace of Dispo	sition (Nama of		IVE,	Data Data	20c. Location			
0	nt of		1 X Burial 2 □ C			State		natory or other pi	,	.0					
Baltimore,	rtant njury		4 Donation 5			FOI		coln Cem			/18/98	Brentw	ood,	Maryland	
Ba	permit. Pages 1 and 2 Department of Heelth s Important: if item 27 is any Injury or other tra once.		21. Signature of Fune	rai Service Liber	1000			Nema and Addrancis G			s Fune	ral Home	. P.	Α.	
_	40244		- Bn	my S	tres		4	739 Balt	imore	Aver	nue, Hy	attsvil:	le, M	D 20781	
			23e Part 1 Enter the shock, or hear to	divease, or com-	plications that on a cause on a	absed the deeth	. Do not ent	ar tha moda of dy	ying, such as	s cardiac	or respiratory a	rrast,		Approximata Intarval Batween	
	Physician					1 .)						Onset and Death	
1	/Medical Examiner		Immadiata Ceusa (Findisaasa or condition	nal	. /	Tolt	(STO	ma	15				100.	
	CXAIIIIIIEI		resulting in death)		a	Due to (or	es a consec	juance of):			, ,			Grath.	
	P #	ne I		_	. (CA (5	try	hour	6	+	ilen		170	6 menthy.	
	certificate be executed iding physician and ise as the bunal-trensit	Examiner	Sequentially list condi	tions,	U	Due to (or	as a consec	uance of):							
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68760,	hysic the b	Medical	that initiated avents resulting in death) Las												
9 x	ing p	Me													
Bo															
	requires that the death een signed by the etter hould be deteched for a	Physician	Part II. Other significa	nt conditione o	ontributing to d	aath but not resu	lting in tha u	ndarlying causa g	jivan in Part	l.	23b. Dld	tobacco use co	ontribute t	o the causa of death?	
P.0	that the de ed by the e	Phy									10	Yes 2 10	3 ☐ Pro	bably 4 Unknown	
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Records,	v require been si should											an autopsy ormed?		ere eutopsy findings vailabla prior to	
00	aw 2 s	ple	·											mpletion of cause daath?	
	0 - 0	Completed									10	Yas 200	11	☐ Yes 2☐ No	
ta	iclan: The certificate rector, pag	Be C	25. Was casa referred	to medical					26 Plac	e of Deet	h (Check only		1		
of Vital	Physician: rthis certific iral director,	To B	examinar? 1 ☐ Yes 2 ☑ No		Hospital:	Inpatient 2 E	ER/Outpatien	t 3 DOA	thar			idance 6 Oth	ner /Sneci	(v)	
	g Ph er thi		27. Mennar of Deeth				28b. Tima of	28c. Inj				how Injury occur		.,,,	
io	ath. :: Afte	atlo	1 Netural 2 ☐ Accident	5 Pending Investigation		in, Day Year)	Injury		ork? ∐Yes 2 □	No					
Division	or Attending after death. Director: After In by the lune	HC	3 ☐ Sulcida	6 Could not b	Z8a. Place	of Injury - At hor	ma, farm, str	eat, factory, office	9				ber or Run	al Routa Number,	
Ö	after a Direct d in b	Certification:	4 Homicida		buildi	ing, atc. (Specify))				City or To	wn, Stata)			
	the Hospital hin 24 hours of the Funeral upletely filled		29a. Cartifiar	Certifying Ph	yalclan: To the	best of my know	rledga, daath	occurred at tha	tima, date ar	nd plece,	end dua to tha	cause(s) and m	ennar es s	stated.	
	Ho Fu Fu	edicai	(Check only 2 one)	☐ Medicai Exam	ninar: On tha b end man	esis of axaminati nar statad.	on and/or Inv	astigation, In my	oplnion, dea	ath occur	red at the tima,	dete and placa,	and dua t	o tha causa(s)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the luneral	Me	29b. Signatura and title	a of certifier				29c. Licar	nsa nu <i>m</i> ber			29d. Date/signe	ed (Month,	Day, Year)	
			10	1/1)_			02	44	12		2/11	15R		
1	()		30. Name and addrass	of parean who	completed servi	a of death flor-	22a) /Time	Print\	1/			1/9	1.0		
- (0)		A CASS	or person who) /_, _	2 7	2 / (Type,	C	/		1	Bung	1 /	P26915	
	CV	to	31. Deta filad (Month,	Day, Year)	32.	legistrar's Signati	ura _		- (cni	17-6				
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State of Maryland / Department of Health and Mental Hygiene

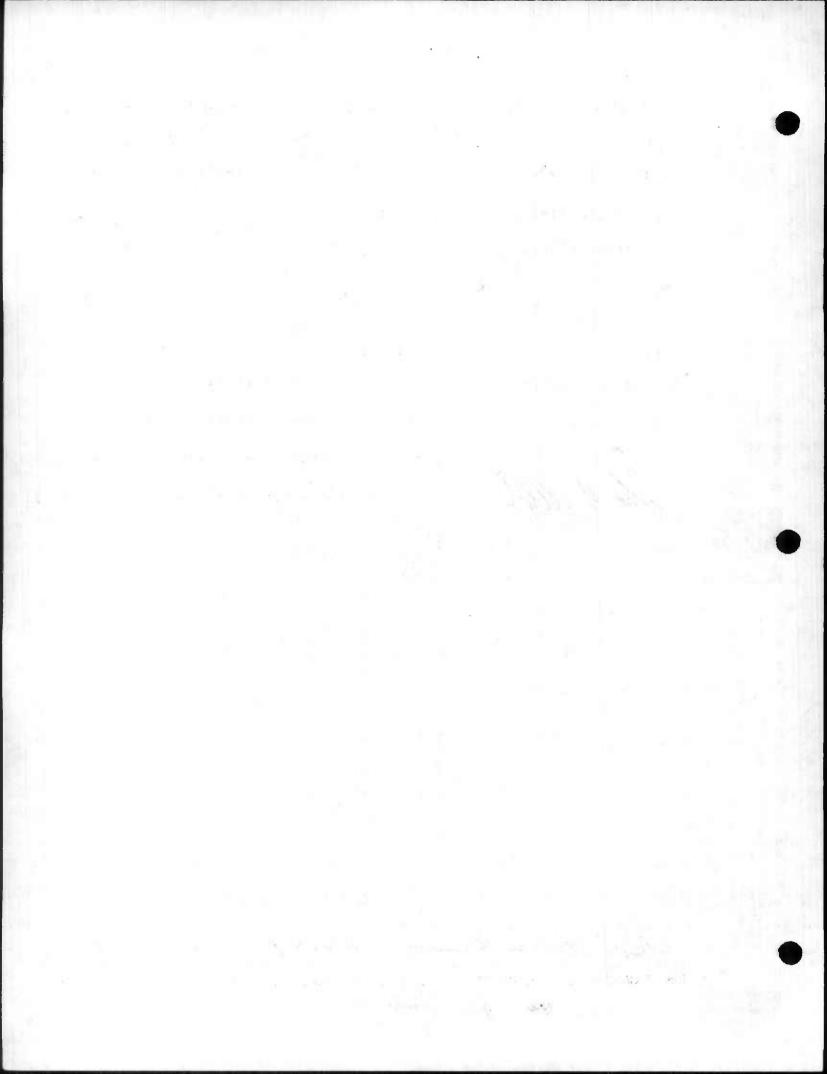
Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath **Physician** Month WILLIAM VOSSLER FEBRUARY 19 1998 2:30 AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BERLIN NURSING & REHAB. CTR. BERLIN WORCESTER If Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number Birthplaca (Stata or Foreign Country),
 W • V A • 6 Sax 7. Aga (In yrs. last birthday) **Funeral** 100 M 2□ F Days Hours Yrs. Director 213-09-2991 Usual Rasidanca of Dacadani the Maryland 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Insida City Limits MD. OCEAN CITY WORCESTER Director 1 Nas 2 No 10e. Straat and Number 10g. Citizan of Whet Country? 10f. Zip Coda 218 HITCHENS AVENUE 21842 USA 'natural', or items 23a Funeral 12. Was Dacadant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva 11. Maritai Status Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. filed within 72 hours after 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 20 No by Specify: WHITE 3 Widowad 4 Divorcad Completed 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Dacedant's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) I Hygiena. Elemantary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 end 2 should be filed wit. Department of Health and Mental Hygient important: if tiem 27 is marked other tha any injury or other traumatic event, that once. ENGINEER STEEL 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maldan Sumama) Be THOMAS M. VOSSLER AGUSTA KLIMM 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) 1136 EDWARD AVE., DEE BAUERNSCHMIDT ALLENTOWN, PA., 18103 20b. Placa of Disposition (Name of cematary, crematory or othar pleca) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Framation 3 ☐ Ramoval from Stata 2-20 4 ☐ Donation 5 ☐ Othar (Spacify) SALISBURY CREMATORY SALISBURY, MD. 22. Nama and Addrass of Facility ULLRICH FUNERAL HOME BERLIN, Mp., 21811 . Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory errast, k, or heert feilura. List only ona causa on aach lina. Approximete Intarval Batwe Onsat and Death **Physician** CEREBROVASCULAR ACCEDENT /Medical Immediata Causa (Final diseesa or condition resulting in daath) Examiner Dua to (or as a consaquence of):
THERO SULERIOTIC CARDIOVISCULAR DE Physician/Medical Examiner physicien end s the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseese or Injury thet initiated avents rasulting In deeth) Last P.O. Box 68760, use as Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by the funeral director, pege 2 should Completed Wara autopsy findings available prior to 24e. Was an autopsy parformad? completion of causa of death? certificate hes 1 ☐ Yas 2 No 1 ☐ Yas 2 No of Vital To the Hospital or Attending Physician: within 24 hours efter death.
To the Funeral Director: After this certifica complataly filled in by the funeral director; g Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Chack only ona) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 10 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Magnar of Death 1 🖾 Natural 28c. Injury at Work? Certification: 28e. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred Division 5 Panding invastigation 1 Yes 2 No 2 Accidant 6 Could not be datamined 3 ☐ Suicida 28a. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 4 | Homicida Medicai 29a. Certifian 1 Cartifying Physician: To the best of my knowledge, daath occurred et tha time, date end place, and dua to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who complated causa of daath (Itam 23a) (Type, Print) EDWIN CASTANEDA 314 FRANKLIN AVE, STE 103 BERLIN, MD 21811 31. Data filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

FEB 2 0 1998



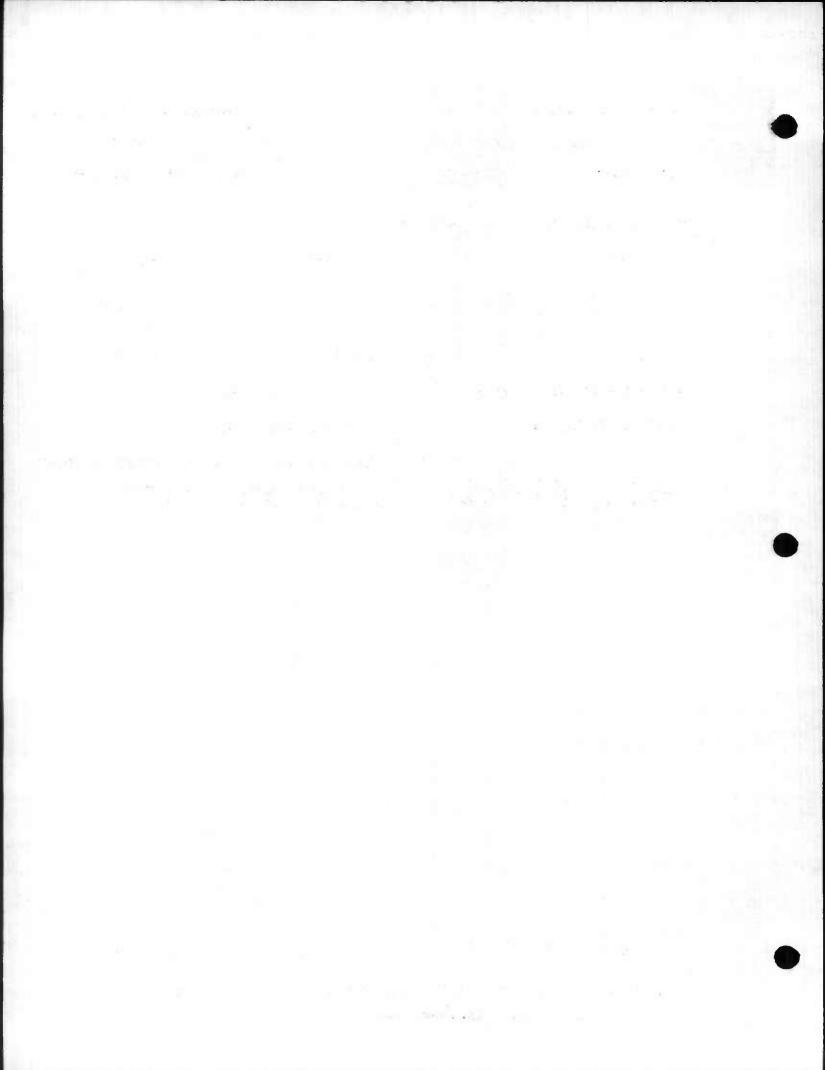
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** NELLIE GRACE WILLIN February 20 1998 6:05 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Wicomico Nursing Home Wicomico Salisbury If Undar 1 Yaar Months Deys Hours Min. 8. Data of Birth (Month, Dey, Year)
FEB. 20, 1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1□ M 2፟ F Country) MARYLAND 212-16-2332 87 Yrs. **Director** Usuel Residence of Decedent Fages 1 and 2 should be filled within 72 hours after death with the Meryland name of Health and Mental Hygiene.

Int. Il liem 27 to marked other than "natural", or items 23s or 28s-f show my or other treumatic event, the Medical Exercise court be notified at 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Directo MARYLAND WICOMICO SHARPTOWN 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 706 MAIN STREET 21861 USA Funeral 13. Wes Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Wes Decedant Ever in U,S. 14. Race - American indian, Armed Forces Bleck, White, etc. 1 ☐ Yas 2 ŽNo If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) BENJAMIN FRANKLIN GRAVENOR 2 GRACE KENNERLY 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, Cify or Town, State, Zip Code) BENNY F. WILLIN/SON P. O. BOX 337, SHARPTOWN, MD 21861 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete Department of Important: If it any injury or o 1 Buriai 2 ☐ Cremetion 3 ☐ Removel from State SHARPTOWN FIREMEN'S CEM 2/23/98 SHARPTOWN, MARYLAND 4 ☐ Donetlon) 5 ☐ Other (Specify) 22. Name and Address of Facility
ZELLER FUNERAL HOME, 106 MAIN STREET, P.O. BOX 207, EAST NEW MARKET, MD 21631 The control of the co **Physician** PARKINSON DISLASE TERMINAL-/Medical Immediete Cause (Finel diseese or condition resulting in deeth) HUNKS, Examiner Examiner attending physician and for use as the burief-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in daeth) Last Due to (or es a consequance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? TRANSIANT 13 gue Mic Attack. Miltiple 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy Semily In peeu has Phematoid Bathaits' certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: funeral director, 25. Wes case refarred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 ☐ Residence 8 ☐ Other (Specify) 1 Yes 2 No 2 this 27. Menner of Deeth Certification: 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Netural or Attending after death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours at Hospital 29a. Certifier edicai 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated, (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) where Feb-20-99. D02026 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Federico G. Arthes, MD 1622A Ocean Pines Berlin, MD 21811 Dey, Year) 32. Register's Signature FEB 2 4 1998 31. Dete filed (Month, Dey, Year) State Registrar

DHMH 16 Rav 6/95

Vellie Willin



State of Maryland / Department of Health and Mental Hygiene

					, maryiana,	Certificate of			eg. No.	3 07	091				
Т	Physici	an	Decedent's Name (First, Michael Pale and Pa					2. Dete of Dee Month February		Voor	Time of Deeth				
	/Medi	cal	4e. Facility Neme (If not institu	t L. Watson	mherl		4b. City, Town, or I		15, 1998 4c. County of		0:30 A. M.				
*	Examir	ier	8022 Wingate Driv		moery		Glendale	Joan of Death		George's					
	Funeral Director		5. Sociel Security Number 577–38–9854	6. Sex 1⊠ M 2□ F	7. Age (In yrs. lest t	yrs. If Under 1 Year Months Deys		8. Date of Birth (Month, Dey December	24, 1912	9. Birthpiece Country). V1rg1n1	(Stete or Foreign				
	land		Usuel Residence of Decedent 10a, Stete 10b, Cour	nty	10c. City, To	wn or Location				10d. I	Inside City Limits				
	Mary	tor	Maryland Prince	e George's		Glend	ale			1	Yes 2□No				
	ith the	Director	10e. Street end Number			10f. Zip Code		1	0g. Citizen of W						
	ath w	ral	8022 Wingate D				20769		U.S.	۹.					
020	within 72 hours efter death with the Maryland ans. than "natural", or Neme 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Maritel Stetus 1 Never Merried 2 M 3 Widowed 4 XX Divorce	larried 1 17 Yes	/8	13. Was Decedent of If Yes, specify Cult		pecify Yes or No- o Rican, etc.)		- American Ir k, White, etc. BLac					
5-0	n 72 ho "natur	Completed	15. Deced (Specify only high	lent's Education hest grade completed)	16	e. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retin	petion during most of wor	kina	16b. Kind of Bus	Business/Industry					
121	within ana. than	mp	Elementery/Secondery (0-12		I-4or 5+)	'life. DO NOT use retire Uphol sterer	ed)		Self-Empl	oved (Pe	rtipod)				
d 2	filed Hygi ther		5th grade 17. Fether's Neme (First, Midd.	le, Last)		opriorsterer	18. Mother's Nen	-		•	:cirea)				
lan	a ta b	To Be	Robert	L. Watson			Louvenia Lane								
Maryland 21215-0020	nd 2 sith a sith a r trau		19e. Informent's Neme/Relation Mrs. Tanya L. Ho			9b. Melling Address <i>(Stree</i> 3022 Wingate Dr				Stete, Zip Cod	le)				
ore,			Mrs. Tanya L. Howard (Daughter) 8022 Wingate Drive Glendale, Maryland 20769 206. Method of Disposition 1 Burial 2 Acremetion 3 Removel from State 206. Place of Disposition (Neme of cemelery, cremetory or other place) 207. Location - City or To												
im	Peges ment of ant: If Its ury or o		4 Donetion 5 Other	3/4/98	Arlington	. Virgin	nia								
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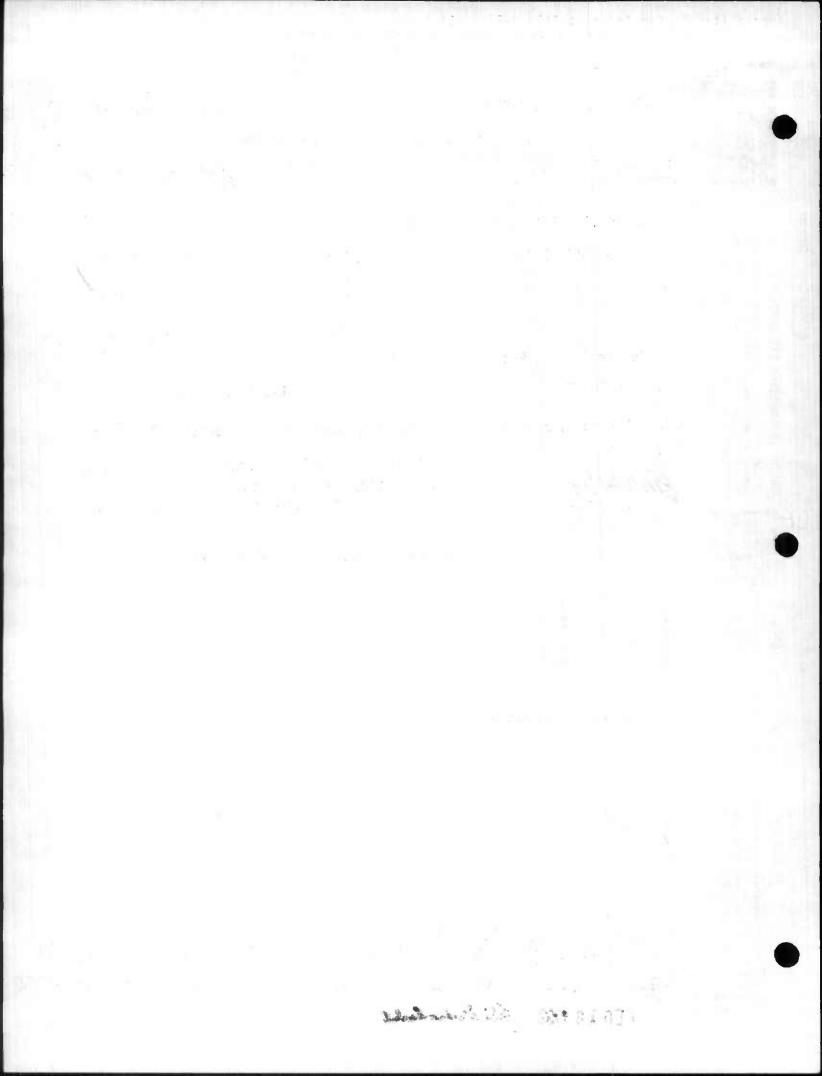
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an	2 sho and h is ma		19a. Informant's Name/Ralationship (Ty	pe, Print)	198	. Mailing Address (Street and Numb	er or Rural Route N	ral Route Number, City or Town, Stata, Zip Code)				
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	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this of completely filed in by the funeral did	edicai	29a. Certifier (Check only 2 Medical Examir	tcian: To the best of	f my knowledge	a, daath occurred et	tha tima, data ar	nd plece, end dua to	tha ceusa(s) and	mannar es r	steted.		
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	(14)		30. Nama and addrass of person who co	mpleted ceusa of da	ath (Item 23e)	(Type, Print)							
			Stanley Watkins, M	I.D. 900	Best Ga	ate Road,	Annapo	lis, Mary	land				
	Sta	-	31. Data filad (Month, Day, Year)	32. Registra	r's Signatura		-						
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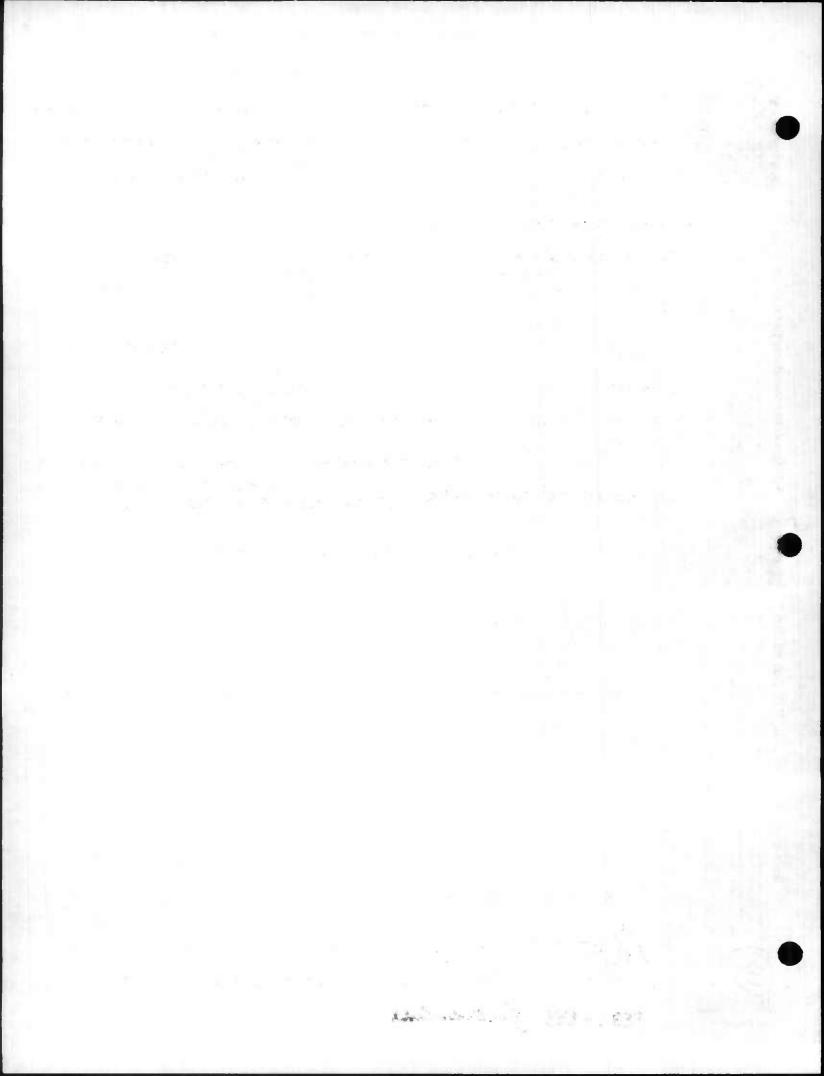
Amend: item #5 Per Informat Film G-758 4-13-98RC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

It	e m i	State of Maryland / Department of Health and 2 per MEO G758 4/3/98 EW Certificate of Death	Mental Hy	ygiene 9 Reg, No.	8 07093								
Physic /Med		Decedent's Name (First, Middle, Last) DEMORRIS ELIZABETH WHEELER	2. Date of D Month FEBR	JARY 12	4 Year 04:40 A								
Exami	iner	4a. Facility Name (If not institution, give street and number) 226(a BRIGHTSEAT ROAP LAN120	or Location of Dea	4c. County of Death FRINCE GEORGES									
Funeral Director		5. Social Security Number 2 1 8 - 5 6 - 6 6 4 7	rs. 8. Date of B		9. Birthplace (State or Foreig Country) MARYLAND								
end **		Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location			10d. tnslde City Limits								
Meny	tor	MARYLAND PRINCE GEORGES LANDOVER			Y√Yes 2□No								
or 28s	Director	10e. Street and Number 10f. Zip Coda		10g. Citizen of	What Country?								
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11215-0620 within 72 hours after deeth with the Meryland ene. than "natural", or items 23s or 28s-f show the Madical Examine. Fruit De notified at	by Funeral	11. Marital Status 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Put 1 ☐ Yes Cive 1 ☐ Yes 2 ☐ No Specify: 1 ☐ Yes 2 ☐ No Specify:	(Specify Yes or Nerto Ricen, etc.)	ce - American Indien, ick, White, etc. by: BLACK									
ore, Maryland 21215-062 s 1 end 2 should be filed within 72 hours if Heelth end Mentel Hygiene. Item 27 is marked other than "natural", other traumatic event, tre Medical Era	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of w	orking.	16b. Kind of B	Susiness/Industry								
21215-0620 within 72 hours af giene. If then "natural", or the Modical Even	Completed	Elementary/Secondary (0-12) Collaga (1-4or 5+) life. DO NOT use retired)	INSURANCE ANNUIT										
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ges 1 end : t of Heelth If item 27 or other tr		TINA WHEELER / DAUGHTER 2266 Brightseat Road 20a. Mathod of Disposition (Name of	, Landov	er MD,	20785 - City or Town, State								
0 00-		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cremetory or other piece)	- COMMING										
		4 Donation 5 Other (Specify) GLENDWOOD CEMETERY 2/20/98 WASHINGTON, D.C. 21. Signature of Furera Service Licensee 22. Name and Address of Facility DUDLEY FUNEDAT HOME											
Balt permit. Depertrimports any inju		DUDLEY FUNERAL H											
		E.M. DUDLEY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one causa on each line.	D AVE, Mac or respiratory	T. RANII	Approximata Interval Between								
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(2)		30. Nama and address of person who completed cause of daath (I) m 23a) (Type, Print)		I EDICUA	15/ 15/ 11/8								
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State of Maryland / Department of Health and Mental Hygiene q

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	17, 1998	February 1	F	5		M	-			-//			9			
30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print)	0744	N ND 00=	A CHTNOWS	00 Em **								3/	(
PHIZIP WISOTSKY, M.D. 11701 LIVINGSTON RD #203 FT. WASHINGTON, MD 20 State 31. Data filed (Month, Day, Year) 32 Registrer's Signature)/44	JN, MD 2074	ASHINGTO	U3 FT. W	N KD #2							/	1.			



State of Maryland / Department of Health and Mental Hygiene (1)

JULI		1. Decedent's Neme (First, Middle, Las	ot)		Certificat	5 01		2. Dete of Dee			3. Time of Death		
Physici /Medic	ai	MYRTLE ELIZABETH					A. Ob. T	Month FEBRUAR			2:15 PM		
Examin	er	4e. Fecility Neme (If not institution, give					4b. City, Town, or L	ocation of Deeth	4c. Count	111-141			
Cilianal		5278 WEST BONIWOO 5. Social Security Number 6. S		e (In yrs. lest birt	hday) If Under	1 Year	CLINTON If Under 24 Hrs.	8. Dete of Birth		PRINCE GEORGE'S			
Funeral Director			□ M 20XF		rs. Months	Days	Hours Min.	(Month, Day APR. 11	, Year)	NORT	plece (State or Foreign http) H CAROLINA		
how		10a. Stete 10b. County		10c. City, Town	or Location					1	IOd. Inside City Limits		
otified	Director		GEORGE'S	CLINT	ON						1 ☐ Yes 2/☐ No		
Den		10e. Street end Number	D MIIDII		10f. Zip		=0=		0g. Citizen of				
Tre 23	Funeral	5278 WEST BONIWOO	12. Wes Decedent	Ever in U.S.	13. Was Dece		735		JNITED 14. Re		American Indien,		
Hygiene. ther than "natural", or items 23s or 25s-f show int, the Medical Examinet must be notified at	by	1 ☐ Never Married 2 ☐ Merried 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yas 2 ☒ N If Yes, Give Yeer or Detes:				dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		ck, White,			
'natural', vical Exa	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16e.	Decedent's Usua (Give kind of wo	el Occup	ation during most of work	ring	16b. Kind of B	usiness/în	dustry		
jiene. r than "natur gre Mevical	Completed	Elementery/Secondery (0-12)	College (1-4or 5	(+)			during most of work d)						
d other than event, n.e.M		12 17. Fether's Neme (First, Middle, Last)	2	Н	OMEMAKEI	3	18. Mother's Nam	e (First Middle I	OWNED		<u> </u>		
ev e	To Be	HENRY JOHNSON					MARY WIL						
E E	-	19a. informant's Neme/Reletionship (7	ype, Print)	19b.	Mailing Address	(Street	end Number or Rui		, City or Town	, Stete, Zip	Code)		
Health e am 27 is ther tra		ALAN WILSON, SON		52	78 WEST	BON	IWOOD TUR	N, CLIN	TON, MA	RYLAN	ND 20735		
T a to		20a. Method of Disposition 1 X Burlel 2 ☐ Cremetion 3 ☐	Removel from State	20b. Plece of	Disposition (Ner	ne of			20c. Location				
6 # 7		4 Donetion 5 Other (Specify		FORT I	LINCOLN	CEMI	ETERY	2/17/98	BRENTW	OOD,	MARYLAND		
Departm Importar any injur		21. Signeture of Fungfal Service Licensee 22. Neme end Address of Fecility FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 2072											
. D = 8 Q		P VISA X	AMM	OW	3401 BI	LADE	NSBURG RD	., BRENT	TWOOD,	MARYI	AND 20722		
		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only	plications thet caused one cause on aach lir	the death. Do n	ot enter the mod	e of dyir	ng, such es cardiec	or respiretory erra	ast,		Approximete Interval Between		
nysician Medical		Immediate Cause (Final								- !	Onset and Deeth		
xaminer		diseese or condition resulting in deeth)	e. DEMENTIA								2-3 YEARS		
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pag		HYPOTHYROIDISM						1 □ Ye	es XXNo	1[Yes 2X No		
s certific director,	Be C	25. Wes case referred to medical examiner?	Hospitel:			Oth	26. Plece of Deat						
五 西	To	1 Yes 2 No 27. Menner of Deeth	1 ☐ Inpatie			' ^	4 LI Nuising no	me 5 Reside			(y)		
After fune	Certification:	1 X Naturel 5 ☐ Pending Investigation	(Month, Da)		jury M	8c. Injur Wor 1 □	k? Yes 2□No		on injury cook				
Director:	Hica	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	ıry - At home, fer	m, street, fectory	, office		28f. Location (St		ber or Rura	al Route Number,		
M Dir	Cert	4 🗆 Homicide	City or Towr	7, State)									
within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	edical	29a. Cartifiar (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	sician; To the bast of inar: On the basis of end menner sta	axamination and	death occurred /or Investigation	et the tir In my o	na, data end piace, pinion, daeth occur	and due to the cored et the time, di	euse(s) end m ata end plece,	annar as s and dua to	tated. o the causa(s)		
rithin To the comple	29b. Signature end title of certifier 29c. License number							2	9d. Dete signe	d (Month,	Day, Year)		
(1)	D46478							FEBRUARY 16, 1998					
6/		30. Nema end addrass of person who c	omplated cause of da	aath (Itam 23a) (Type, Print)								
		SURESH A. PATEL, M.D., 7501 SURRATTS ROAD, #307, CLINTON, MARYLAND 20735											
Stat	_	31. Dete filed (Month, Day, Year)	32 Registre	r's Signeture	dalle								
Registra	ar	FEB 1 8 1998	Strake 10	Paraden And									

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State of Maryland / Department of Health and Mental Hygiene

				Claic of W	iaryiari		rtificate			aria iv	iona i i	Reg. No.	98	07096
	Physic /Medi		1. Decedent's Name (First, Middle, Le	/	SEL	LM.	AN.				2. Date of D Month	Day	9 8	3. Time of Death 9 · 55 4
	Examl		4a. Facility Neme (If not institution, gire	ve street and number	r)			-1	4b. City, To	wn, or Lo	cation of Dee	th 4c. Co	ounty of Deel	th
			LAUREL REGIONA	L HOSPITA	L				Laure	_		P:	rince	George's
	Funeral Director		The state of the s	Sex 7. A 1 □ M 2 ☑ F	ge (In yrs. le 95	ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of B (Month, L	irth ay, Year) 19 2	9. Bird Co Ash	thplece (State or Foreign buntry) IVille, N.C.
	p 2		Usuel Residence of Decedent 10a. State 10b. County		10- 04-	Town and a								
	the Marylan 28a-f show notfled at	ctor	Maryland Prince	George's	Toc. City	Town or Lo								10d. Inside City Limits 1½ Yes 2 □ No
	h with th	ai Dire	10e. Street and Number 14615 Philip Co	urt, Apt-	Y2		10f. Zip	Code 2070	8				n of What Co ited	ountry?
020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Experient must be notified at	by Funeral Director	11. Meritel Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 28 If Yes, Give Year or Dates:	No		Was Deceded of Yes, special			gin? (Spo , Puerto	ecify Yes or N Ricen, etc.)	lo- 14.	Race - Ame Black, Whit	ericen Indian, ee, etc. Black
21215-0020	s 1 and 2 should be filed within 72 hours t Health and Mentai Hygiene. Item 27 is marked other than "natural", other traumatic event, the Medical Exe	Completed	15. Decedent's E (Specify only highest gr. Elementery/Secondery (0-12)	ducetion ade completed) College (1-4or	5+)	life. I	dent's Usual kind of work DO NOT use	retired	1)	of work	ing		d of Business/Industry	
Maryland	should be filed within and Mental Hygiene. marked other than amatic event, tree.	Beautician 17. Father's Name (First, Middle, Last) Marge Gudger Beautician 18. Mother's Name (First, Middle, Last) Ella Hall												
ary	and Menidils marked	-	19e. Informant'a Name/Relationship (Type, Print)		19b. Meilir	ng Address	(Street		_	/ Route Num	ber, City or T	own, State, 2	Zip Code)
	1 and 2 : Health ar em 27 is other trau		Ferlene N. Wat	kins - Nie	ece	1461	5 Phi	lip	Court	. Ar	ot-Y2,	Laure		
Baltimore,			20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State	ce	metery, crem	sition (Nam natory or ot	e of he <i>r pl</i> ac	ce)		Date /20/98	20c. Local	tion - City or	Town, Stete
	permit. Page Department of Important: If any Injury or		21. Signature of Funeral Service Lice		Qual	22	Name and	Addre	ss of Fecility	,	1E, Inc		ngle,	VA
	Physician // edical Examiner		23a 11. Enter the disease, or come succk, or heart failure. List only Immediate Cause (Finel disease or condition resulting in death)	plications that cause one cause on each I	ed the death. line.	Do not ent	er the mode	of dyin	g, such as	cerdiac (N. E.,	arrest,	ig con,	D.C. Approximate Interval Between Onset and Death 2 w/s.
п		-	resolding in death)			as a conseq								F 11
Т	bed nsit	든		b		H4120	0019	•						Hew His
68760,	rificate be executed g physician and as the bunal-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C	Due to (or	as a conseq	uence of):							
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Box	death cert e ettendin ed for use	ciar												
, P.O.	that the ed by th deteche	by Physician/	Pert II. Other eignificant conditions of		buting to death but not resulting In the underlying ceuse given In Part I.							Yee 2/2		robably 4 Unknow
Records,	\$ 2° ≥ 8	Completed to									24a. Wa	s en autopsy formed?		Were autopsy findings eveileble prior to completion of cause of death?
Vital R	rician: The law certificate has b rector, page 2 s		25 Was note referred to medical									Yes 2	40	1 ☐ Yes 2 ☐ No
5		To Be	25. Was cese referred to medical exeminer? 1 Yes 2 10	Hospital: 1 Inpati	ioni oli	R/Outpetien	t 3 DO/	Oth	or.		(Check only		Jon	- 14. A
ion of	5 6 5		27. Menner of Deeth 1 Natural 5 Pending 1 Accident investigatio	28a. Date of Inju (Month, De		28b. Time of Injury		c. Injun Worl			me 5 Res 28d. Describe			cny)
Division	To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: Al completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	ne, farm, stre	eet, factory,	office				(Street and Nown, Stete)	lumber or Ru	ural Route Number,		
	n 24 hour Ne Funera	edicai	29a. Certifier (Check only one) 1 Certifying Ph	yalclan: To the best niner: On the basis of and manner st	or examination	ledge, death on and/or inv	occurred a restigation,	t the tim	ne, dete and pinion, deet	d place, a	and due to the ad at the time	ceuse(s) an , date end pla	d manner as ace, and due	s steted. to the cause(s)
	Within To the Comp	M	29b. Signature end title of certifier	uile	N	2		_	number	21			igned (Mont	h, Day, Year)

State Registrar

30. Manne and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

T.S. AUTLAMD 5632 Annapolis Ret # 13 Bladens Gung 207 10

31. Date filed (Month, Day, Year)

FEB 19 1938

A. Auturbuld

FIRST STREET, SEC. Sec. 15.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 18, Dey 1998 Month **Physician** FEB. DONALD F. WEAVER 4:20 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country)
 PA 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** 1**∑**M 2□ F 68 195-22-2880 Yrs Director 6, 1929 Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Manylan Department of Health and Mental Hygiene. Important: If time 72 is a rested other than "natural; or items 23a or 23a-f show any injury or other treumatic event, the Manylan Examine meat the notified as 1 Yes 2 No Director PRINCE GEORGES MD. HYATTSVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4416 OLIVER ST. 20781 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Maritel Stetus Armed Forces: 1947-IN Yes, Give 1947-Yeer or Dates: 1967 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify: þ 3 Widowed 4 Divorced WHITTE Completed Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. MARSHALL Elementary/Secondery (0-12) College (1-4or 5+) INSPECTOR U.S. NAVY AND 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be JOHN F. WEAVER DOROTHY GLUNT 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) SHIRLEY M. WEAVER/WIFE ITEM 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removal from Stete
4 Donetion 5 Other (Specify) GEORGE WASHINGTON CEMETERY 2/21/98 21. Signeture of Funeral Service bicensee 22. Name end Address of Fecility M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner siclan end buriel-transit Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest physician sthe buriel P.O. Box 68760. Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ate has been signed by pege 2 should be detac Records, by 24b. Were eutopsy findings aveileble prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital of Attending Physician: effer death. Director: After this certifica 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Deet Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) In by 4 Homicide To the Hospital of within 24 hours e To the Funeral D 12 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29d. Dete signed (Month, Dey, Yeer) 29c. License number 30. Neme and edd ess of person with completed cause of deeth (Item 23a) (Type, Print) AVE. TACOMA BALK, MD 7600 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State Registrar FEB 19 19

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			State of	waryian		rtificat					Reg. No.	070	199	
Dhuain	la.	1. Decedent's Name (First, Middle, L	ast)	7.79	179	100	N 19			2. Dete of Deeth 3. Time ot Death Month Dey Year				
Physic /Medi		Edward Linds	say Wil	liar						Feb.	17.1	998 6	: 25 F	
Exami		4e. Facility Name (If not institution, gi	1 000		. 1	11		^		ation of Death	_	of Death		
				mor		Home			nsbo	-		ashin	aton	
Funeral			Sex 7. 1 X M 2 ☐ F	Age (In yrs. I	lest birthdey, Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birt (Month, De Apr. 23	h y, Year)	Country)	State or Foreig	
Director		213-09-8540 Usual Residence of Decedent		83	115.			L	1	Apr. Z	3,1914	Mar	yland	
land		10a. State 10b. County		10c. City	, Town or L	ocation						10d.	Inside City Limits	
r 28a-f show	to	Maryland Washi	ington	300	1	Boons	boro					10 PM	1 ☐ Yes 2 ☒ No	
death with the ms 23e or 28s	Funeral Director	10e. Street and Number				10f. Zip	Code	3.19			10g. Citizen of V	What Country?		
23e or	O E	8507 Mapleville	Rd.			102		2171	3			U.S.A.		
items 2	nera	11. Marital Status	12. Wes Decede	ent Ever in U,	S. 13.	Was Dece	dent of H			city Yes or No lican, etc.)	- 14. Rac	e - American I		
72 hours efter netural', or ite		1 Never Married 2 Married	Armed Force							ican, etc.)		ck, White, etc.		
rai',	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s:		1 Yes	2LX NO	Specify:			W W	hite		
"netural",	Completed	15. Decedent's E (Specify only highest gi			16a. Dece	dent's Usu	el Occup	ation	at of workin	0	16b. Kind of Ba	usiness/Indust	ry	
2	npie	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT u	se retired	d)	n or morning	9				
e filed w al Hygier other tr	S	11				manag	ger		121120		feed			
d off	Be	17. Father's Neme (First, Middle, Las Jacob O. Willi						18. Moth		ame (First, Middle, Meiden Sumeme) Bertha Ecker				
should by a Mente marked imatic even	10													
h end la mer		19a. Informant's Name/Relationship Irene Williar/ wi									er, City or Town,		de)	
ges 1 and 2 should be filed will to f Health and Mental Hygiens If Item 27 Is marked other the or other traumatic event, the		20a. Method of Disposition	rre	20h P	lace of Disp	Map1		те ка	. B	Date	ro, MD :		Ctata	
Peges tent of I nt: If Ite		1 ☑ Burial 2 ☐ Cremation 3 l		ite _ Ce	emetery, cre	metory or o	other pied	,						
		4 □ Donation 5 □ Other (Spec		Pi	pe Cre						nr. Lin		MD	
permit. Departr Importu any inje		21. Signature of Fineral Service Licensee 22. Name and Address of Facility Hartzler Funeral 6 E. Broadway Union Bridge.									uneral	Home		
40200		6 E. Broadway Union Bridge, MD 2												
Physician	H	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
/Medicai Examiner	23	disease or condition resulting in death) a										- +	me	
Adminion	-	resulting in death)	A CONTRACTOR	Due to (or	r as a conse	quence of)	:					I		
De tis	nine		b	Carrie Antylkine						Mar.			min	
and and Il-trar	хап	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) the lightest energy of the												
cate be executed physicien and the burial-transit									mande	n pine	-	>		
phy:	opa	resulting in death) Lest Due to (or es e consequence ot):												
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death certifi e ettending d for use es	Physician/Me	David Other david								1				
thet the de ned by the e deteched (ıysı	Part II. Other eignificant conditions	THE RESERVE OF					en in Part	1.				a causa of death'	
signed b		Uspertinia	Carcian	m Pa	entité	2	ich	5	at harmonic months	10	Yea 2LINO	3 Probabi	y 4 Linknow	
een sign	d by	nelites	P								an autopsy	24b. Were	autopsy tIndings	
S O	Completed		Tempor	- ver	مسلسر	Dur	un			perfo	rmed?	comple	ole prior to etion of cause	
The law ate has b page 2 s	mc									10,	Yes 2□ No		s 2 No	
certificate rector, pag		25. Wes cese referred to medical						OO Dies	a at Da ath			1016	98 2 100	
	o Be	examiner?	Hospital:	atient 2 🗆 I	EB/Outpatio	nt 3 D	Oth	or:		(Check only o	dence 6 □Oth	or (Coonifu)		
£ # @	h:	27. Manner of Death	28a. Date of I	niury	28b. Time o		28c. Injur Wor	-			now injury occur			
Attending For death. actor: After by the funer	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	М		k? Yes 2□	No					
	Certification:	3 ☐ Suicide 6 ☐ Could not letermined	286. Place of	Injury - At ho	me, farm, st	reet, factor	y, office		2		Street and Numb	per or Rurel Ro	oute Number,	
2 = 5	Cert	4 Homicide	building,	etc. (Specify	7					City or To	vn, State)			
vithin 24 hours effe To the Funeral Dir completely filled in	edical (hystotan: To the be minar: On the basis and manner	of examinet										
ithin o the	M	29b. Signature and title of certifier	4.10 (Hallio)	5.4.00.		29	c. Licens	e number	100		29d. Date signe	d (Month, Dev	, Year)	
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		30. Name end eddress of person who							ID 21-	74.0				
		Vasant Datta 31. Date tiled (Month, Dey, Yeer)		Mill istrar's Signat		наде	rsto	WII,	עו בוו	40				
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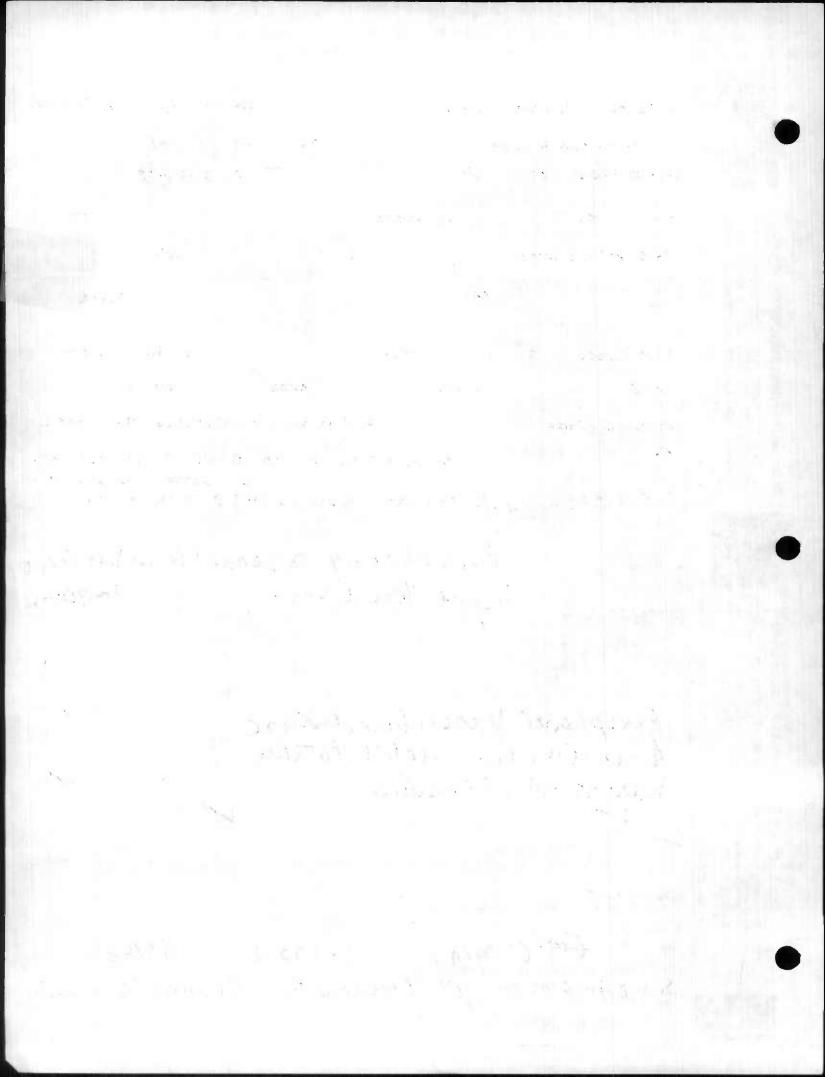
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) Month **Physician** o3, Yaar 98 9:50am Adams William Lester /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva straet and number) 4c. County of Death Examiner Baltimore 2610 Pelham Avenue if Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Months Days Hours Min Yrs. 85 215-05-9454 Director NC Usual Residence of Decedent the Maryland 10c. City, Town or Location r 28a-f show 10a. State 10b. County 10d. Inside City Limits MYes 2 No Md NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours efter death with Department of Health and Mental Hygiene.

Timportant: If item 27 is marked other than "natural; or items 23a or important: If item 27 is marked other than "natural; or other traumatic event, I'm feptical Examines must be any lighty or other traumatic event, I'm feptical Examines must be USA 21213 2610 Pelham Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas ☐ Yao If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NA Laboer various trades 12th Grade 18. Mother's Name (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middla, Last) Adams Adams Anna Ralph 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 21213 19a. Informant's Name/Relationship (Type, Print) 2610 Pelham Avenue Baltimore, Maryland Wilbert Adams 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata *Burial 2 Cremation 3 Removal from State 03-06-98 Arbutus, Md. Arbutus Mem. Pk. Cem. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeçal Service Licansee 22. Name and Address of Facility Baltimore, Maryland 21202 elan WM.C.March FH 1101 E. Norht Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final yease Severe disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): signed by the at d be detached for Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uea contributa to the ceuee of death? 3 Probably Unknown 1 ☐ Yee 2 ☐ No by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed has 1 Yes 22 No 1 Yes 2 No or Attending Physician: after death. Director: After this certifica Be 26. Place of Death (Check only one) Other: 4 Nursing Home Sesidenca 6 Other (Specify) Hospital: ^oL 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined To the Hospital or Atta within 24 hours after de: To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifies 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Heleria Ave Baltinone Md 2/22 31. Date filed (Mor 32. Registrar's State relia Davidson Registrar



for use as the bunial-transit permit. Pages 1, 2, 3 should

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	12	y fille	tion,	the
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospi	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMEN CERTIFICAT	IT OF HEALTH AND MEN E OF DEATH	ITAL HYGIENE REG. NO.	07101				
	1. DECEDENT'S NAME (First, Middle, Lest)	CHARLES ARM	STEAD M	ARCH ON 19	3. TIME OF DEATH				
	A STATE OF THE PARTY OF THE PAR		R 1 YEAR IF UNDER 24 HRS. 7. D	Wonth, Day, Year)	BIRTHPLACE (State or Foreign Country)				
~	9a. FACILITY NAME (If not institution, give stree	t end number) 9b. CIT	Y, TOWN OR LOCATION OF DEATH	4RCH 31, 1932	OF DEATH				
СТОР	RESIDENCE OF DECEDENT	EHABILITATION CENTER GI	EN BURNIE	A.A	, COUNTY				
DIRECTOR	MARVLAND A. A	, COUNTY 10c. CITY, TOWN	0 1	NIE	10d. INSIDE CITY LIMITS? 1 VES 2 NO				
	10e. STREET AND NUMBER		101. ZIP CODE		N OF WHAT COUNTRY?				
FUNERAL	10 15 HOWAY	2. WAS DECEDENT EVER IN U.S. ARMED 13	. WAS DECENDENT OF HISPANIC OF		. RACE — American Indian,				
BY F	1 Never Merried 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2 NO IF YES, GIVE WARJOR DATES -19-52 / 11-03-54	It yes, specify Cuban, Mexican, Pue 1 ☐ YES 2 ☑ NO Specify:	erto Ricari, etc.)	Black, White, etc. Specify:				
TED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	10N 18e. DECEDENT'S USUAL (Give kind of work done life. Do NOT use mileted)	during most of working	16b. KIND OF BUSINESS/INDUS	TRY				
COMPLET	12 + HGRADE	SHIPPING		SUPERMA	RKET				
	17. FATHER'S NAME (First, Middle, Last) WILLIAM R	DOELL ARMSTEAD	18. MOTHER'S NAME (FI	irst, Middle, Maiden Surname)	WILLIAMS				
TO BE	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRES	SS (Street end Number or Rural Route i	Number, City or Town, State, Zip Co	rde)				
·	CHARLOTTE ARMSTE	20b. PLACE AND DATE OF DISPO		DATE 20c. LOCATION - CH	E. HD. 21239				
	4 Donation 5 Other (Specify) 21. SIGNATURE OF UNERAL SERVICE-LICEN	CROWNEVILLE	CEMETERY 8-	5-98 CROWNSI					
	*(W_)	· (on)	TO SEPH H. I	3 ROLUN JR. FE	HORE, MD. 21217				
	23. PART I. Enter the diseeses, or con shock, or heart fellure. Lis	applicatione that caused the deeth. Do not enter tonly one cause on each line.	r the mode of dying, such as	cardiac or respiratory arrest	Approximate interval Between				
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	CORONARY	1 ARTE	24 DISI	EASE GYEARS				
_	CHR	ONIC OBSTRUCT	IVE PULL	MONARY D	ICEASE 14 VEARS				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF):	170 PHP	ENIA	50 VEAPO				
TIFIC	CAUSE (Disease or Injury thet initieted events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):	120 TAK	ENGL	SU (EAR)				
CER	d	LOSENITAL	ATPERI	ENSION	127EARS				
ICAL	PART II. Other significent conditions of	ontributing to death but not resulting in the u	inderlying ceuse given in Pert	i. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE				
MEC	DID TOP ACCOUNTS CONTROL			×	OF DEATH?				
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check		1					
HYSI		Inpetiant 2 ER/Oulpatient 3 DOA 4 Nu 28e. DATE OF INJURY 28b. TIME OF	raing Home 5 - Residence 8 - (Other (Specify) DESCRIBE HOW INJURY OCCUR	red September 1				
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) INJURY M	WORK? 1 YES 2 NO						
TED	3 Suicide 8 Could not be 4 Homicide determined	26e. PLACE OF INJURY — Al home, farm, street, technical building, atc. (Specify)		LOCATION (Street and Number or I City or Town, Stete)	Rural Route Number,				
COMPLETED		N: To the best of my knowledge, death occurred at the							
	290 SIGNATURE AND TITLE OF DERTIFIER	On the besis of examination end/or investigation, in my	opinion, death occured at the time,		GNED (Month, Day, Year)				
TO BE	SPINAME AND ANGRADES OF PERSON WHO C	PMPLETED CAUSE OF DEATH (I NEW RTALTYDO, Arint) O	D14160 March 02, 1998						
	HAKUIT SIN	9HM.D. 54(0-A)	LICHIE HIGH	tWAY, BA	LTIMORE				
	31. DATE FILED (Month, Day, Year) MAR 0 6 1998	32/AGGISTAAN'S SIGNATURE Julia Day doon-Mandalls	rent (cre	4D-2(2	23				

DHMH-18 Rev 1/89

State of Maryland / Department of Health and Mental Hygiene

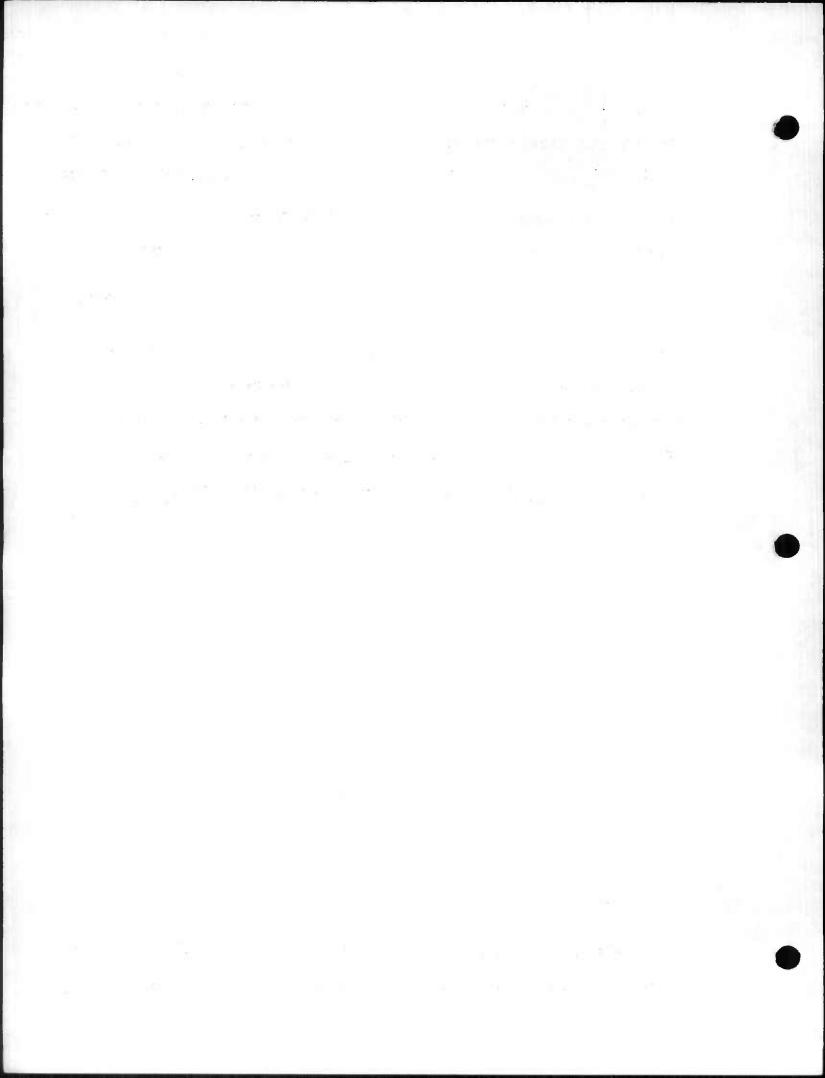
Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth MARCH 3 Day 1998 **Physician** 10:02am CHARMIE Μ. AGEE /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROSEDALE BALTIMORE SQUARE HOSPITAL FRANKLIN If Undar 1 Yaar If Undar 24 Hrs.

Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Year)
May 14,1904 9. Birthplaca (Stete or Foreign 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Deys Virginia 406-18-8092 93 Yrs. **Director** Usual Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Nedical Examiner number or northed at Middle River 1 Yas 2 No Baltimore Md. Director 10e. Street and Number 10f. Zlp Code 10g. Citizan of What Country? 21220 USA 10028 Icabod Lane Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lt Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - American Indien, 11. Maritai Status Black. Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or item any injury or other traumetic event 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Naver Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: by 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 5th College (1-4or 5+) own home Homemaker 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surnema) Mae Barker Etna Vanburen Hall 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda)
10028 Icabod Lane Baltimore Md. 21220 19e. Informent's Neme/Relationship (Type, Print) Thomas Hensley / son 20b. Plece of Disposition (Neme of cematary, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete X□ Burial 2 □ Cremetion 3 □ Removal from Stete 3/5/98 Baltimore Md. Holly Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerei Sarvice Licensee 22. Nama and Address of Facility Connelly Funeral Home of Essex om 23a. Parf1. Enter the disaese, or complica shock, or heert teilure. List only one 300 Mace Ave. Baltimore Md. 21221 Approximate Intervel Between Onset end Death lications thet caused the death. De not enter the mode of dying, such es cardiac or respiratory arrest the cause on each line. **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in death) Examiner Examiner icien and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Last attending physicien for use as the buria Physician/Medical Dua to (or as a consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to completion of cause ot death? 24e. Wes en eutopsy Completed certificate 1 ☐ Yas 2 ☐ No 1 Yes Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica 25. Was case reterred to medical exeminer? Be 28. Plece of Deeth (Check only one) exeminer?
1 Yes

27. Manner of Deeth Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? Neturel 5 Pending 1 Yes 2 No 2 ☐ Accident investigation 6 Could not be determined 3 Suicida 28a. Place of Injury - At home, ferm, straet, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide Cartifying Physician: To the best of my knowledge, deeth occurred et the tima, date end place, and dua to tha ceuse(s) end menner as stated.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the tima, date end place, end due to the ceuse(s) and manner stated. 29a. Certifier Medical npletaly (Check only one) within 2 To the I 29b. Signatura and title of certifiar 29c. License number 39/02 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SITU-WN YAVE MD 2323 Olleans St. Raldmine 31. Dete tiled (Month, Dey, Year) State MAR 06 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:59 pm June Elizabeth Brent 3 March 1998 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore City If Under 24 Hrs. 8. Date of Birth Hours Min. May 19, **Examiner** Memorial N/A Hospita Union 7. Age (In vrs. last birthday) 5. Sociel Security Number If Under 1 6. Sex 9. Birthpiace (State or Foreign **Funeral** 1□ M 2X F Months Days 219-01-9276 Yrs. Director 80 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3428 Elmora Avenue 21213 S. A. и. 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Miller Mary Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Howard J. Brent (Husband) 3428 Elmora Avenue, Baltimore, Maryland 21213 20b. Place of Disposition (Neme of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 4 ☐ Donation 5 ☐ Other (Specify) 3/6/98 Baltimore, Maryland 21. Signeture of Funeral Service Licensee 22 Name and Address of Facility Schimunek Funeral Home Inc. Buin a wellow 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervai Between Onset end Death **Physiclan** /Medical Immediete Cause (Final Preumonia disease or condition resulting in death) Examiner Due to (or as a consequenca of) pration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Malnutrition 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24e. Wes an autopsy 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

AU417643579259 March 3, 1998

Elizabeth To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funera

State

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 7 I Hygiena. other than "n

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If item 27 is marked other 1 any Injury or other traumatic event.

use as the burial-transit

director, page 2 should

After this certificate has been

Director:

Baltimore, Maryland 21215-0020

Medical

29a. Certifier (Check only

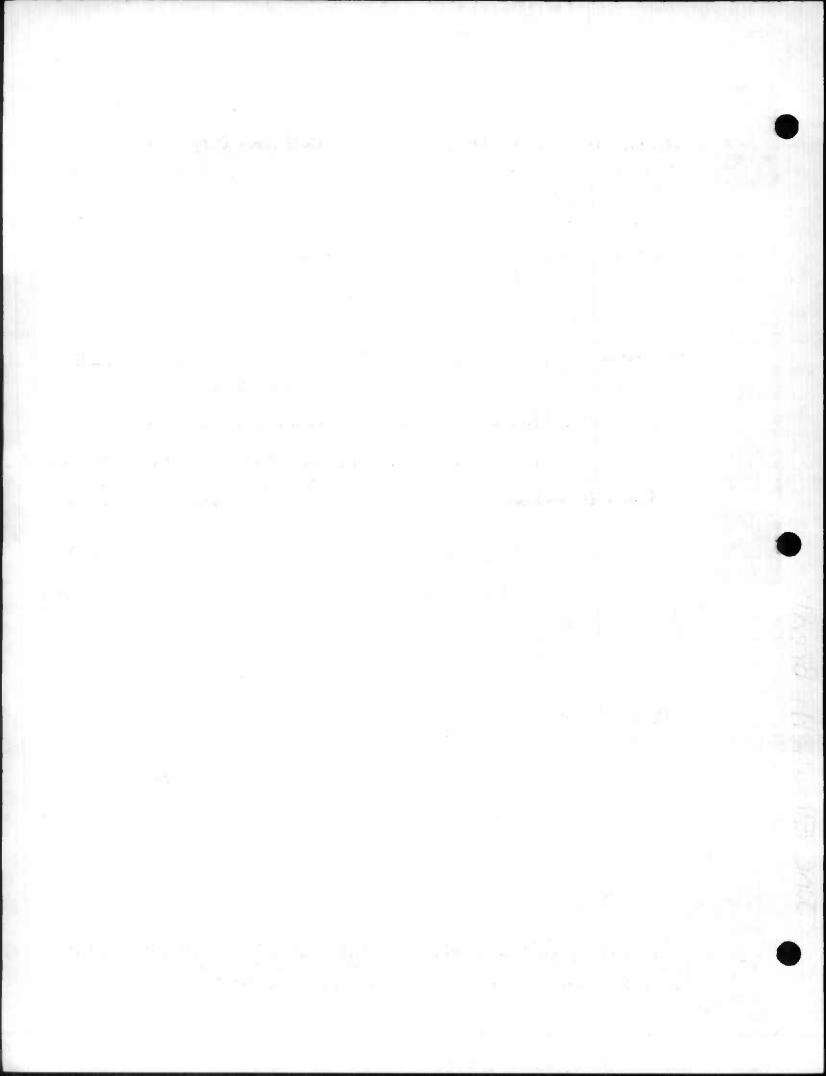
29b. Signature and title of certifier

Registrar

completed cause of death (Item 23e) (Type, Print) Kimberly Johnston East University Parkway Bultimore, MD

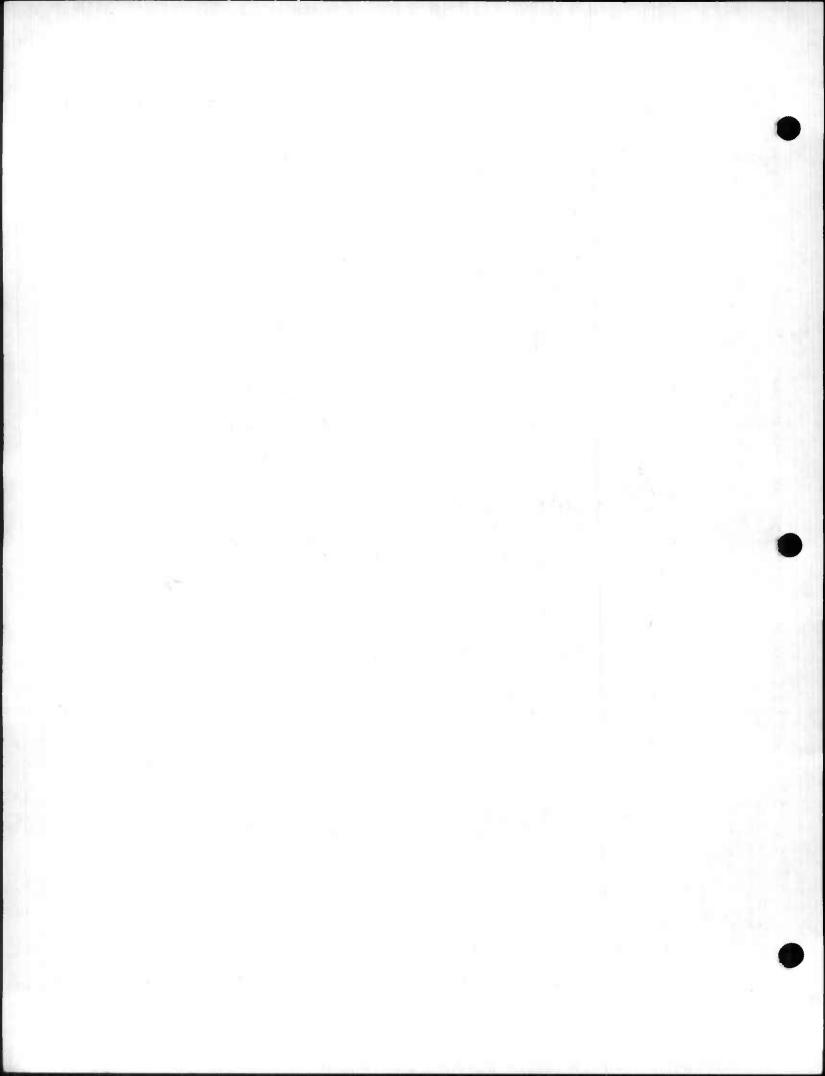
32. Registrant Signature

31. Date filed (Month, Day, Year) MAR 06



State of Maryland / Department of Health and Mental Hygiene 9 8 0 7 1 0 4

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and	A		Usual Residence of Decedent 10a. Stete 10b. County		10c. City,	Town or I	Location					10d. Inside City Limit			a City Limits	
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21215-0020 d within 72 hours efter death with the Maryland	al', or items 23a or 28a-f show Examiner must be notified at	by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Ayes 2 N If Yes, Give Year or Dates:		1		ecify Cuba		to Rican, etc.)			k, White, e	Black		
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aryla should	arke	J.	Seabron Brook						Pearl							
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Hospital or Attending to hours effect death.	To the Fundral Director: completely (illed in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		ry - At hom . (Specify)	e, farm, s				28f. Location City or 7	(Street ar		er or Rural	Route N	lumber,	
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F ₹	F 8		1 June 7 11	129c. License number 29d. Date signed (Month, Day, Year 1998) 11em 23e) (Type, Print) 2600 Liberty Heights Avenue 2					,							
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			30. Name and address of person who co	completed cause of de	ath (item 2	3e) (Type	Print)	00 1	ibert	dei	lits	Au	enne	7	1215	
	CAC		31. Date filed (Month, Dey, Year)	32. Registra	r's Signatur	re	2/10		у	-	V . C 4	, (00		~	1100	
	Sta Bogietr	ie Or	MAR OF 10		Jani	- A	and DO									



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Year SONJA MAE BREIDENSTEIN MARCH 1998 12:40 P.M. 4e. Fecility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death GILCREST NURSING HOME HOSPICE TOWSON BALTIMORE If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) If Under 1 Year 5. Sociel Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 1 □ M 2 🗓 F Days 212-40-6396 Yrs. 59 5/13/38 PENNSYLVANIA Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No BALTIMORE PARKVILLE 10e. Street end Number 10f. Zip Coda 10g. Citizan of Whet Country? 8654 OAK ROAD USA 21234 12. Wes Decedant Evar in U,S. Armad Forces? Wes Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No If Yas, Giva Yeer or Datas: 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) STABLE HAND HORSE TRAINING 11th GRADE 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) UNAVAILABLE JEAN WOLFF 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. tnformant's Name/Ralationship (Type, Print) LEONARD C. BREIDENSTEIN, JR. 8654 OAK ROAD BALTIMORE, MD 21234 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 5 Othar (Specify) 4 Donation METRO CREMATORY, INC. 22. Nama and Addrass of Facility 3/6/98 CATONSVILLE, MD 21. Signatura of Funaral Sarvica Licansas JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. 23e. P. rt1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause of a each tine. TOWSON, MD Approximata tritarvat Batween Onset end Death tmmadiata Causa (Final CIYTHOSIS diseasa or condition rasulting in death) Sequantially list conditions, if any, taading to immadiata cause. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequanca of): 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy parformed? 24b. Wara autopsy findings evailabla prior to completion of causa of daath? 1 ☐ Yas 2 No 1 Yas 2 No 26. Placa of Death (Check only ona)

Physiclan /Medical Examiner

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Department of Health ar
Important: If Itam 27 is
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Physician

/Medical

Examiner

Funeral

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28a-f show

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7 is marked other than "natural", or items 23a or 28a-f shor traumstic event, the Medical Examinar must be multified at

"natural", or

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Baltimore, Maryland 21215-0020

Box 68760

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Examiner Physician/Medical signed by the

paga 2 : cartificata Attending Physician: director this Director: After this d in by the funaral death. hours after Hospital or To the Hospital within 24 hours a To the Funeral C complately filled

> State Registrar

Part tt. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ð Completed Be 25. Was casa rafarred to medical axaminar? Othar: 4 Nursing Homa 5 Rasidanca 6 Nothar (Specify) Certification: To 1 Yas 20 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Yaar) 27. Mannar of Daath 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 Homicida Medical 29a, Cartifler

12 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data end ptece, end due to tha causa(s) and mannar as stated.
2 Madicat Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and ptace, and due to the causa(s) and mannar stated. 29c. Licanse number 29d. Date signed (Month, Dey, Year)

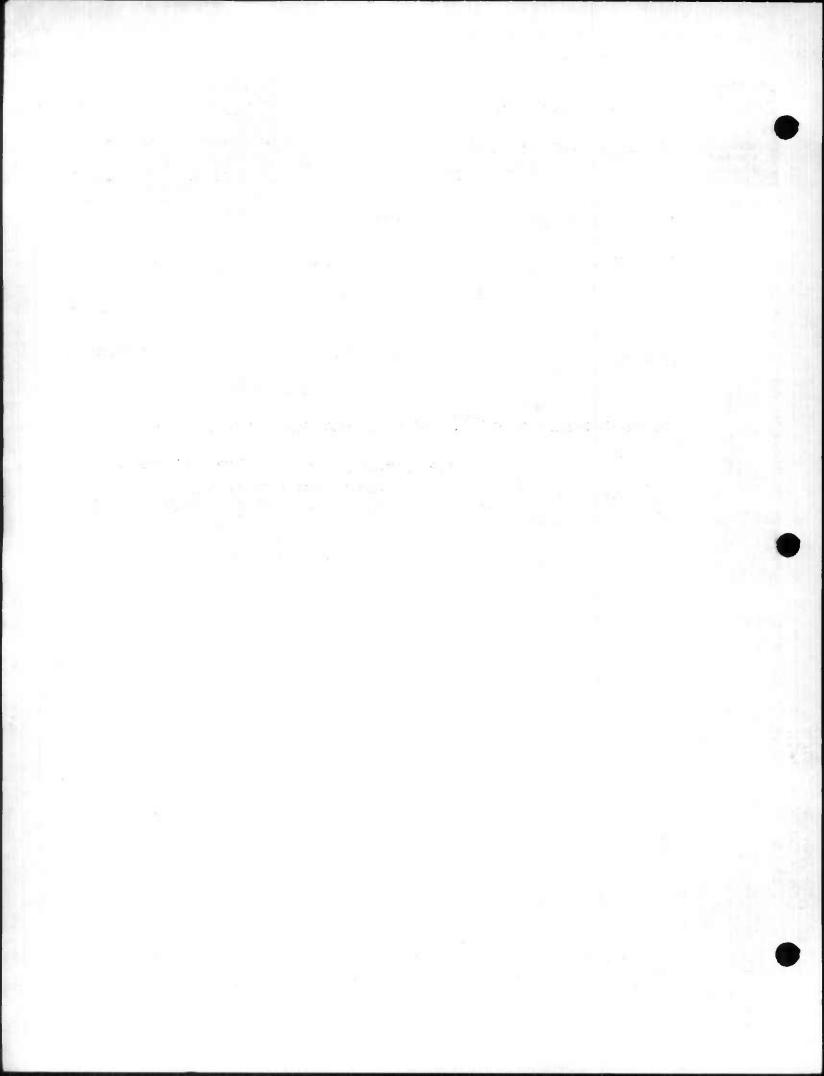
29b. Signatura and title of certifia

sa of daath (Itam 23a) (Type, Print) le

N. Charles St. Balto. Md 21204

1998

31. Data filed (Month, Day,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Date of Daeth 3. Tima of Death Month **Physician** Dolores Briscoe E. 1857 /Medical 4e. Facility Nema (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Shock /Truuma Hospital Baltimore University of Maryland 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) JAN, 31, 1920 MARY LAND Funerai 218-01-3588 10 M 20 F 78 Yrs. Deys Hours Director Usuat Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumetic event, the Medical Examiner must be notified at BALTIHORE CITY 1 Yas 2 No Director MARILLAND 10e. Street end Number 10g. Citizan of Whet Country? 502 etus

12. Was Dacedant Ever in U.S.
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1 | Yes | 2 | No 21230 USA 13. Was Decedant of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amaricen Indien, Black, Whita, atc. 11. Maritat Stetus permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Health end Mental Hygiena. Important: If Item 27 is marked other than "natural", or thei any injury or other traumatic event. In exercise. 1 ☐ Navar Married 2 ☐ Married 1 Yas 2 No If Yas, Giva Yaar or Datas: Specify: Specify: BLACK py 3 Widowed 4 □ Divorced Completed 16e. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Bustness/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 11 +H GRADE PRIVATE DOMESTIC 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumame) VERNON LILLIAN SEWELL 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda) SYLVIA SMITH SISTER) 1010 W. BALTIHORE STREET, BALTIHORE HD. 21223

a of Disposition (Nama of Date 20c. Location - City or Town, Stata 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata MD. NATIONAL CEMETERY 3-9-98 LAUREL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signetyre of Funaral Sarvice Licanses 22. Nama and Addrass of Facility 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximately 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest. BALTIHORE, NO. 21217 Approximate Intervel Batween Onset and Deeth **Physician** /Medical Multisystem Organ Immediata Causa (Final 5 days disaasa or condition resulting in death) Examiner Shock Saquentially list conditions, if any, leading to immadiata causa. Entar Undarlying Couse (Diseese or injury that initiated avants rasulting in death) Last Dua to (or es e consequance of): Thorocia Spine fusion Physician/Medical Dua to (or as a consequence of): 20 days 23b. Did tobacco usa contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yss 2 No 3 Probably 4 Dohknown duorder, Hx of Congestive Heart failure 24b. Were autopsy findings aveitebla prior to complation of cause of death? 24a. Was en eutopsy Ischemic Coronary Artery Disease, Dinbete, Mellity 1 Yas 2 No 1 ☐ Yas 2 No 25. Was cesa rafarred to medicel 26. Placa of Daath (Check only ona) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 28e. Date of Injury (Month, Day Yaar) 27. Mannar of Deeth 28d. Describa how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Panding invastigation 1 Naturat 1 Yes 2 No 2 Accidant 12 98 6 Could not be determined 3 ☐ Suicida 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata) 4 Homicide Leadenhall St APT-502 Home 29a. Certifiar 100 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and piaca, and due to tha causa(s) and manner as steted.
2 Madical Examinar: On tha basis of axamination end/or invastigation, in my optnion, deeth occurred at the time, dete and piace, end dua to the cause(s) and mennar statad. Medical

P.O. Box 68760, Records, Division of Vital

ate has been signed by the attanding physician and page 2 should be detached for usa as the burial-transit

After this certificate has

filled in by the funeral

Saltimore, Maryland 21215-0020

Show

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

State Registrar

29b. Signature and title of certifier Fellow Critical Care Medicine

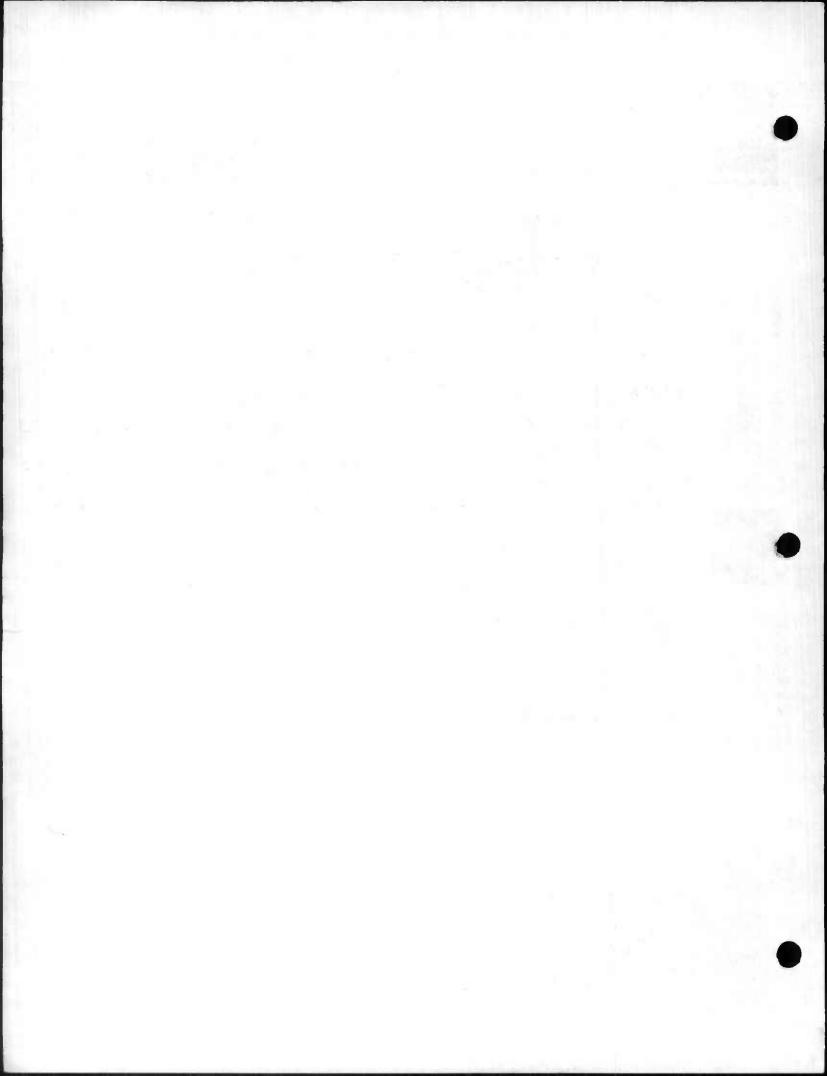
29c. License number H0051578 29d. Data signed (Month, Day, Year)

30. Name and addrass of person who complated cause of daeth (Itam 23a) (Type, Print)

Dept of Apolleciology University of MO raig 1700dsel1 31. Data filed (Month, Day, Year) 32. Registrar's Signature

MAR 06 1998

(Check only



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month F. 28 AM BALLARD ILLIAN MARCH 1998 /Medical 4e. Fecility Name (If not institution, giva street end number) 4b City Town or Location of Deeth 4c. County of Deeth Examiner GILCHRIST HOSPICE CENTER BALTIMORE LOWSON If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) 5. Social Sacurity Number If Under 1 Yeer 6. Sex 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** 1□ M X)F Days 95 Yrs Director Nov. 3, 1902 212-36-9695 Maryland Usual Residence of Deceden the Maryland 10e. Stete 10b. Counts 10c. City, Town or Location 10d. Insida City Limits ? is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at Baltimore Maryland **Baltimore** Director 1 ☐ Yes 2 X No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6307 Pinehurst Rd. 21212 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (XNo If Yas, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, White, etc. 11 Marital Status permit. Peges 1 and 2 should be filed within 72 hours effer. Oppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examples 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: White by 3 X Widowed 4 □ Divorced Completed 15. Decadent's Education (Specify only highest greda completed) 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12 College (1-4or 5+) Pianist Baltimore Co. Gov't. 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Thomas Hicks Anna Louise England 19e. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lillian B. Grieb / Daughter 4833 Deep Point Dr., Chestertown, MD 21620 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Crematory 3/5/98 Baltimore, MD 22. Neme and Addrass of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD. trunar 21286 23e. Pert1. Enter the diseesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final CEREBRAL YASCULAR disaasa or condition resulting in deeth) Examiner Due to (or es e consequence of) MEUMONIA attending physician end for use as the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Records, P.O. Box 68760 Physician/Medical the Dua to (or as e consequence of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION ò Completed 24b. Were autopsy findings evelleble prior to 24e. Wes en eutopsy performed? peen HYPOTHYROIDISM complation of cause of deeth? ete has bage 2 s 1 ☐ Yes 2 No certificete 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Be 25. Wes case referred to medical director 26. Piece of Death (Check only one) axeminar? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA this funeral 27. Menner of Deeth 28e. Date of Injury (Month, Dey Yaer) 28c. Injury et Work? 28d. Describe how Injury occurred Medical Certification: 28b. Time of After 5 Pending investigation 1 Neturel To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Steta) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner stated. 29a. Certifier 29b. Signeture 29c. License number 29d. Data signed (Month, Day, Year) D28673 - MD MARCH 4, 1998

6565 N. CHARLES ST. SLUTE 207; BACTIMORE ND 21204

State Registrar

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

M.D.

32. Registrar's Signeture

M. FRIEDLANDER

31. Dete filed (Month, Dey, Yeer) MAR 0 6 1998

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2 Date of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** Ruby Bastress 4, 1998 6:08 PM March /Medical 4e Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Franklin Square Hospital Center Rosedale If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 4-15-05 Birthplece (State or Foreign Country)
 MD 5. Sociel Security Number 213-74-0859 7. Age (In yrs. last birthday) **Funeral** 1□ M 2♥ F Months Deys Hours 92 Yrs. Director Usual Rasidence of Dacedeni 72 hours after death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examiner must be not first at MD Baltimore Rosedale 1 ☐ Yas 2 X No Directo 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 8406 Philadelphia Rd. 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritei Status Black, White, etc. 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: 1 ☐ Nevar Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: white þ 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast greda completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry el Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) h and Mentel should be William F. Roth Anna C. Meeks 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) permit. Pages 1 end 2 st. Department of Health and Important: If item 27 is m sny injury or other traum 8406 Philadelphia Rd. Rosedale, MD 21237 Edward Bastress / son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State Loudon Park 3-7-98 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility
Cvach/Rosedale Funeral Home 21. Signifure of Funeral Service Lic 1211 Chesaco Ave. Rosedale, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Deeth **Physician** Immediete Ceuse (Final disease or condition resulting in deeth) /Medical 7 days Pneumonia Examiner Due to (or es e consequence of) Physician/Medical Examiner attending physician and for use es the bunal-transit The law requires that the death certificeta be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Box 68760 Dua to (or as a consequence of): resulting in deeth) Last Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? o the signed by t 1 Yes 2 No 3 Probably 4 Unknown ۵ Dementia Records, þ 24b. Were eutopsy findings evellable prior to completion of cause of deeth? been sig 24e. Wes en eutopsy performed? Completed Cerebrovascular accident this certificate has Ovarian carcinoma 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

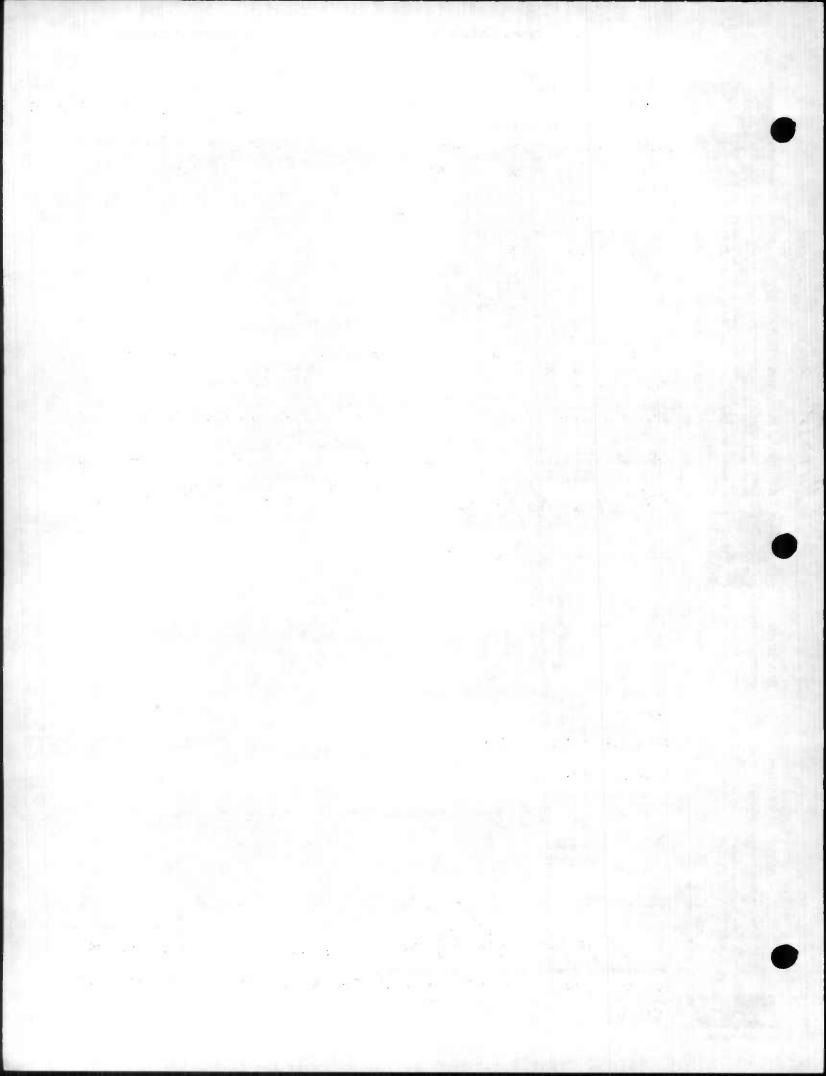
To the Funeral Director: After this certifics completely filled in by the funeral director; 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Naturel 2 Accident 5 Pending Investigation 1 TYes 2 No 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) RD2344 March 4, 1998 K 30. Name and address of berson who completed cause of death (Item 23e) (Type, Print) DR Anthony Samphilipo MD 9000 Franklin Square Drive Baltimore Maryland 21237 32. Registrar's Signature 31. Dete filed (Month, Dey, Year) State MAR 06 1998

DHMH 16 Rev 6/95

Registra

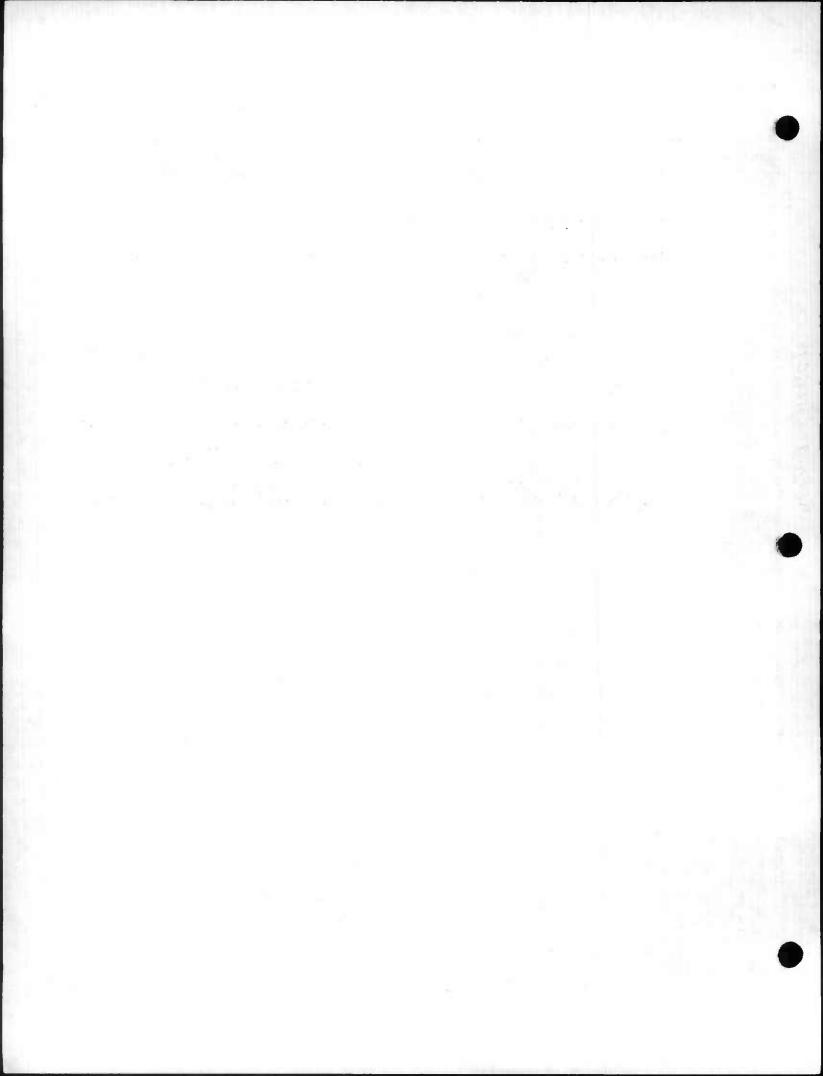
BASTRESS, R.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ?

						Certificate	of Death		Reg. No.		
	Dhta		1. Decedent's Name (First, Mid	die, Last)				2. Date of D	-	Van	3. Time of Death
	Physic /Medl		SOPHIA MARI	E BURCH				MARC	h 2	1998	12 50M.
	Exami		4a. Fecility Name (If not instituti	on, give street and number)		4b. City, Town	, or Location of Dea	th 4c. County	of Death	
٦			ST. ELIZABETH	NURSING HOM	E		BAL	TIMORE	N/	A	
	Funeral Director		5. Social Security Number 141–54–4958	1 TH 257 E	ge (In yrs. last birt 94	hday) If Under 1 Months I		Hrs. 8. Date of B	irth Pay, Year) 7, 1903		place (State or Foreign
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	th v		10e. Street and Number	STONE COURT		10f. Zip Co	22024		10g. Citizen of	What Coun	
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.h 21215-0020	ours efte	by	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Give		1□ Yes 2X		,	Specif		
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4)			23a Party Entar the disease, or heart failura. Lis	or complications that cause	d the death. Do n	ot enter the mode of	KENS AVEN f dying, such as car	diac or respiretory	errest,	21	Approximata Interval Between
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			30. Name and address of person	who completed cause of	death (Item 23a) (Type, Print)	21141			1,	
1			KRIS F. K	UHN UD	2007. 1	Benson An	Suna Sa	ita 227	Ballia	ewo.	98 NO 21227
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State of Maryland / Department of Health and Mental Hygiene 2 9 07 1 1 0

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₹ #		10a. Stete 10b. County		10c. City	, Town or Loc	cation					1	0d. Inside City Li
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0.0	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Yeer or Detes:			Vas Decede f Yes, specif 1 ☐ Yes 2[Specify Yes or No rto Rican, etc.)		eck, White,	etc.
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Department of important: If any injury or once.	-	21. Signeture of Funeral Service Licar		Kin				1 Garde	LL			f Deeth gomery 9. Birthplece (Stete or Fore Country) Poland 10d. Inside City Light Country Interest Country? American Indien, White, etc. White einess/Industry or Interest Country In
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth Month BOUGHAN 1998 HILDA March 2:08 pm 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth HOSPITA BAITIMORE In vrs. lest birthday) If Under 1 Year It Under 24 Hrs. 8, Date of B 5. Sociei Security Number Samaritan 8. Date of Birth (Month, Dey, Dec 29, 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign 1□M 2]() F Months Deys Hours Yrs. Maryland 82 212-10-5109 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits TY Yes 2 No Baltimore Maryland N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21213 3575 Dudley Avenue U.S.A 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Yeer or Detes: 1 Never Married 2 Married 1 Yes 2√ No Specify: Specify: White 3X Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) Anne Jones James Atkinson 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4423 LaPlata Avenue, Baltimore, Maryland 21211 Charles Boughan (Son) 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) Baltimore, Maryland 3/6/98 Loudon Park Cemetery 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Alan Seitz, Jr. Funeral Home 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. 3818 Roland Avenue, Baltimore, Maryland 21211 immediete Ceuse (Finel 1 day . Acute Myocardial Infarction disease or condition resulting in death) Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 爰 Unknown 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Minpatient 2 □ ER/Outpetient 3 □ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

Funeral

Director

28a-f show

6

Herns 23a

should be filed within 72 hours after ond Mental Hyglene.
marked other than "natural", or iter

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records.

Division of Vital

Examiner must be notified at

traumatic svent, the Medical

permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is tranked other any injury or other traumatic svent.

Director

Funeral

by

Completed

the Maryland

Examiner Physician/Medical ģ Completed Be Certification: To

27. Menner of Deeth

1 Neturel

2 Accident 3 Suicide

4 - Homicide

29b. Signeture end title of certifier

29a, Certifier

sician and buriel-transit that the death certificete be executed physician the signed by the e e Hospital or Attanding Physician: The law requires 1 a fours after death.

24 hours after death.

Enveral Director: After this certificate has been signn elicity filled in by the funeral director, page 2 should be leiely filled in by the funeral director, page 2 should be To the Hospital or within 24 hours aff To the Funeral Di completely filled in cal

10

State Registrar much

5 Pending investigetion

6 Could not be

Genre

P11403

1 Yes 2 No

28c. Injury et Work?

15 Certifying Phyeiclen: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Dey, Year) march 3, 1998

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

BOLTIMORE MD

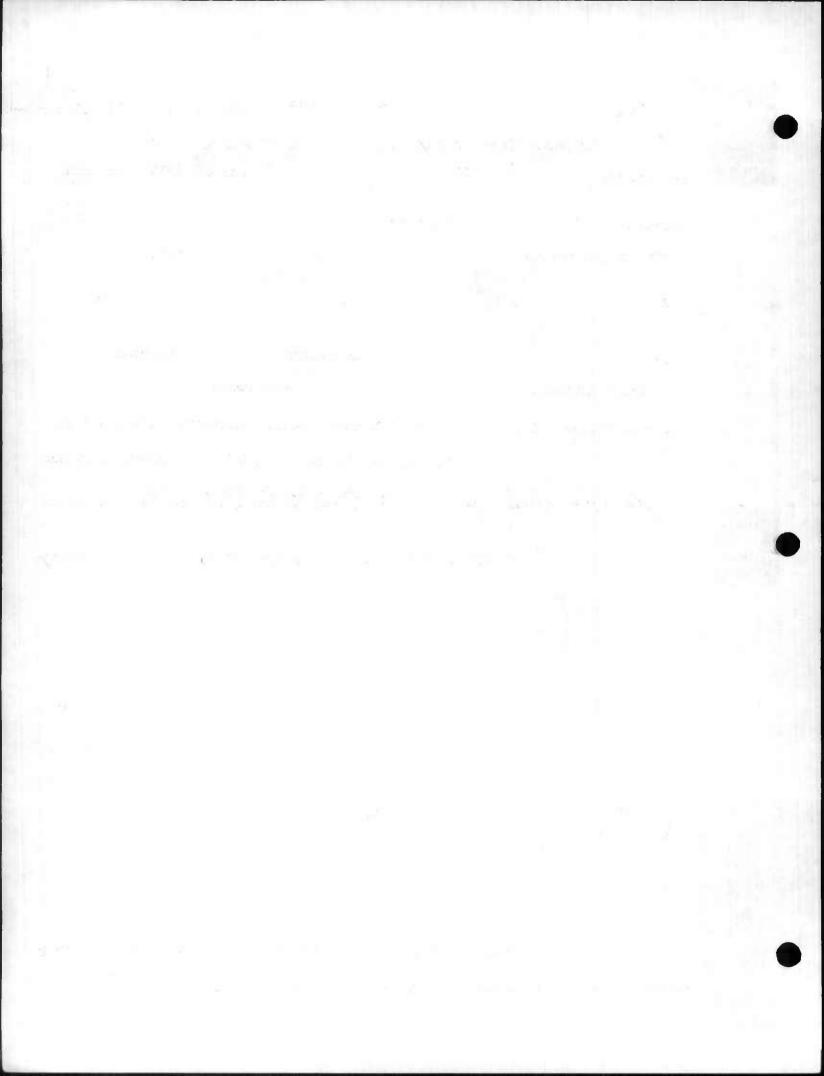
31. Dete filed (Month, Dey, Yeer) MAR 06 1998

NAWAKO KURODA MD

Good Samarston Hospital 5601 Loch Raven Blud. 32. Registrer's Signeture his Davidson-Randelle

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth February 28 **Physician** Vincent Francis Carlin, Sr. 1998 1:20 AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Deaton Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months Days 213-09-1141 86 Yrs. March 16 1911 Massachusetts Director Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wookes Examiner must be notified at 1 Yes 2 □ No N/A Baltimore Maryland Directo 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 1310 Southview Road 21218 United States Funeral deeth 12. Was Decedent Ever in U,S. Amed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Detes: WW II 14. Rece - American Indien, 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Introductant: If fire 27 is marked other than "natural," or file any injury or other traumatic event, "as was any injury or other traumatic event," as was a factoring. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p White 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Broker / Agent Insurance 4 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Vincent Francis Carlin (Unknown) 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Geraldine M. Carlin / Wife 1310 Southview Road Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 XBuriel 2 ☐ Cremetion 3 ☐ Removal from Stete 3-2-98 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith Cem. Baltimore, Maryland 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licensee any ir Mitchell-Wiedefeld Home, Inc. tural. Ette 6500 York Road Baltimore, MD 21212 Approximate Intervel Between Onset end Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Pneumonia 2 weeks Examiner Due to (or es e consequence of): Physician/Medical Examiner 2 weeks Congestive Heart Failure attending physician end for usa as the burial-transit The law raquires that the death certificete be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Atherosclerotic Heart Disease 10 years Box 68760 Due to (or es e consequence of): usa as t Acute Renal Failure 2 weeks 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. P.0. the 3 Probably 4 Unknown signed by 1 Yes 2 No Dementia Division of Vital Records, by 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? been signal 24e. Wes en eutopsy performed? Completed paga 2 s certificate hes 1 ☐ Yes 2 No 2 No or Attending Physician: 25. Wes case reterred to medical exeminer? Be 28. Piece of Deeth (Check only one) To the Hospital or Atlanding Physicismithin 24 hours after death.

To the Funeral Director: After this ce Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 - Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es steted. edicai (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end piece, and due to the ceuse(s) end menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) James PG. DO 1346

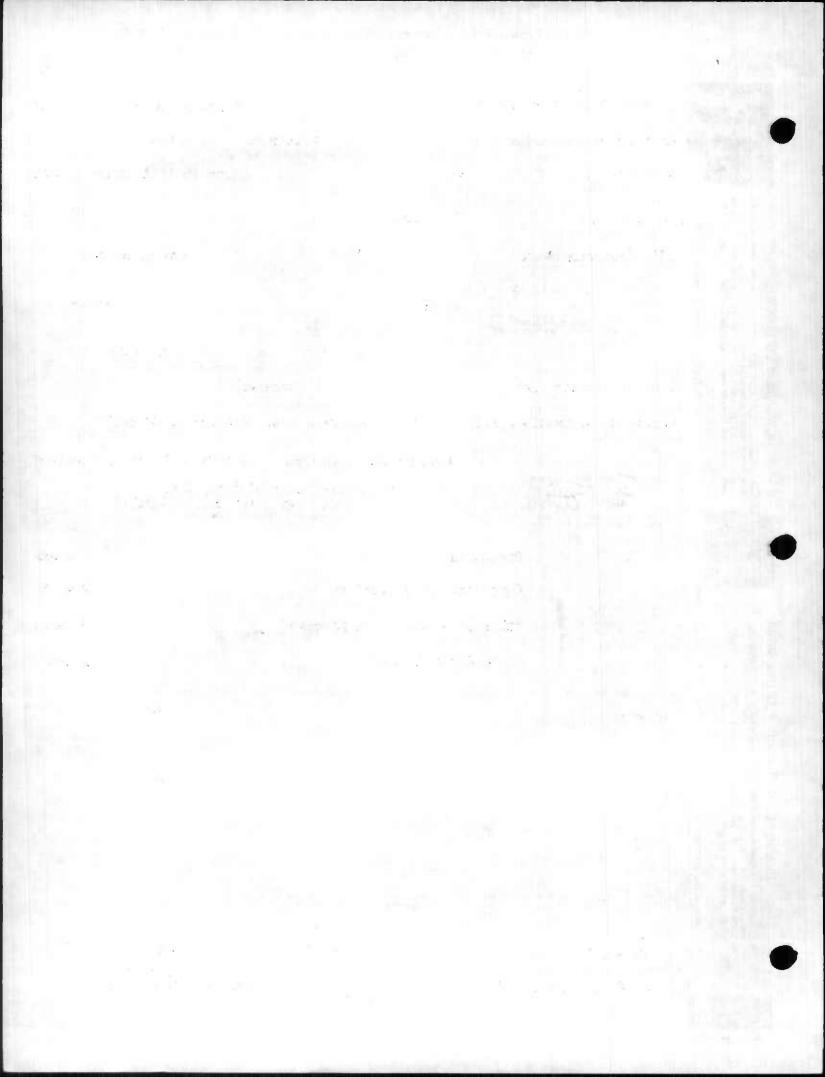
State Registra

31. Date filed (Month, Dey, Year) MAR 06

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

James P. G. Flynn, M.D. trar's Signature 32. Registrat's Signature

611 South Charles Street Baltimore, Maryland



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:10 pm LENA CLARK 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL SECOURS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 28 F 214-03-5173 89 Yrs. SEPTEMBER 16, 1808 VIRGINIA Director Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f show Examiner nant be notified at N/A 1 Yes 2 No MARYLAND BALTIMORE CIT Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? LAFAYETTE 21216 U.S.A 2636 W. Completed by Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status d 2 should be filed within 72 hours effer of the end Mental Hyglene.
7 is marked other than "naturel", or iter traumatic event, the Medical Examiner. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HURCH MINISTER 4 YEARS Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be facen of Health end Mental Inc. If Item 27 Is marked of PARKER MAMIE CMN-UNKNOWN. DILLIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) SEROME PATTERSON (NEPHEW) 773 LINNARD STREET, BALTIMORE, MARYLAND DISOS If Item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Depertment of Important: If eny Injury or OUDEN PARK CEMETERY 3-5-98 BALTIHORE, MARYLAND 6 Other (Specify) JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 21. Signature of B Pervice Licens 2140 N. FULTON AVENUE, BALTIMORE, MARYLAND 01217 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth **Physiclan** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medicai the Due to (or Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? page 2 should 24a. Was an autopsy Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funaral Director: After this certification prompletely filled in by the funeral director; p. Be 25. Wes case referred to medical 26. Piace of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death them 23e) (Type, Print)

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32. Registrar's Signature

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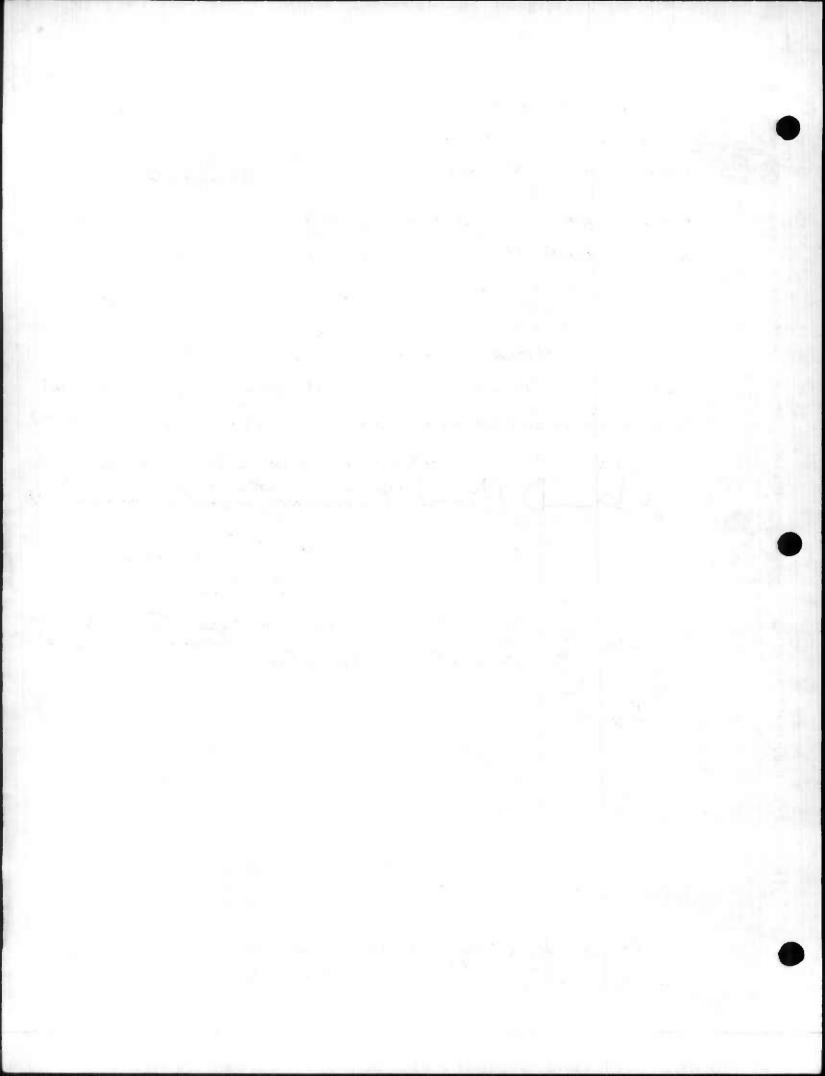
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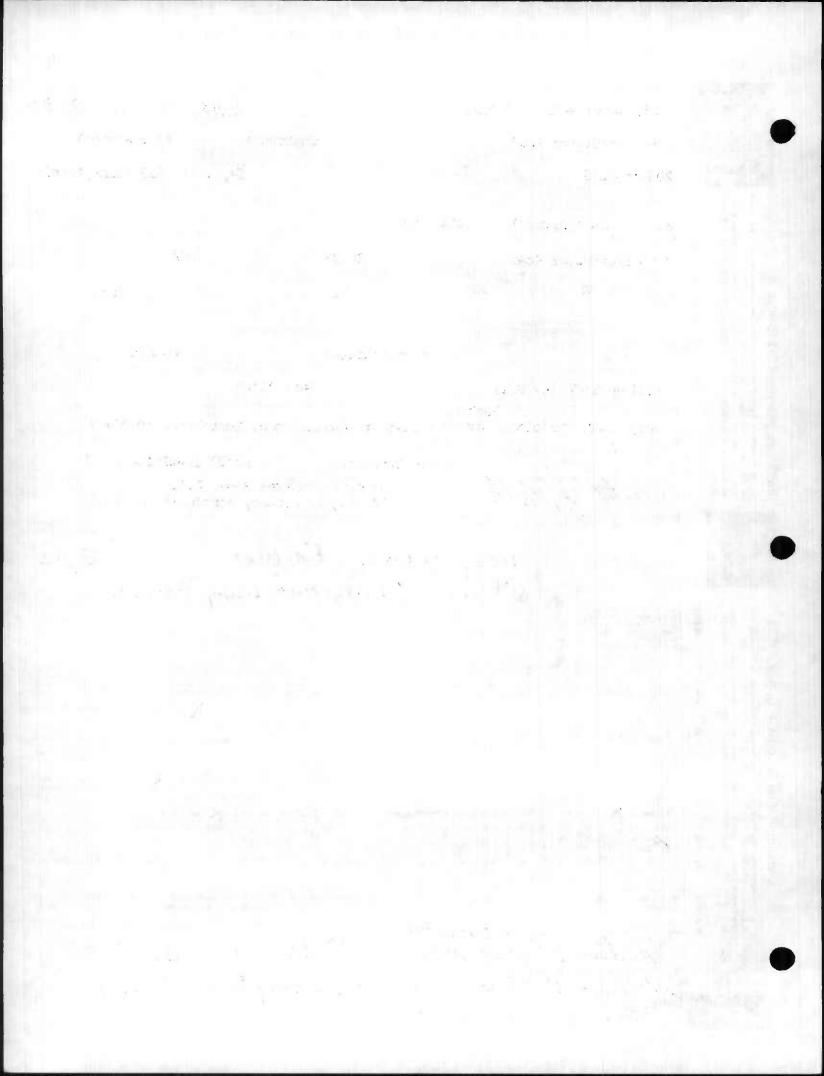
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month ATHLIA LARR Ĺ 2:17 PM MARCH 1998 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore N/A If Under 1 Year Months Deys If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) 8. Dele of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Months 218-52-4298 1 □ M 2 🛛 F 50 1-2-48 CA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Raspeburg 1 ☐ Yes 2 ☑ No 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 5648 Arnhem Rd. 21206 USA 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic OrigIn? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Merried 1 ☐ Yes 2√ No Specify Specify: White 3 Widowed 4 Divorced 16e. Decedant's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 12 5+ Public Relations Rep. Non-Profit 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) James S. Carr Vera Miller 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Gordon Carr / son 5648 Arnhem Rd. Baltimore, MD 20b. Place of Disposition (Neme of cemetery, crematory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 3-6-98 Catonsville, MD 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD enese 23a. Pert1. Enter the disease, or complications theticaused the deeth. Do not anter the mode of dylng, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death Immedieta Ceuse (Final diseese or condition resulting in death) Dua to (or es e consaguança of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceusa (Disease or Injury thet Initieted evants resulting in death) Lest Dua to (or es e consequance of) Due to (or es e consequance of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings avelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? all No 1 Yes 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Inpatient 2 NO 2 ER/Outpetient 3 DOA 28b. Time of 28d. Dascribe how injury occurred

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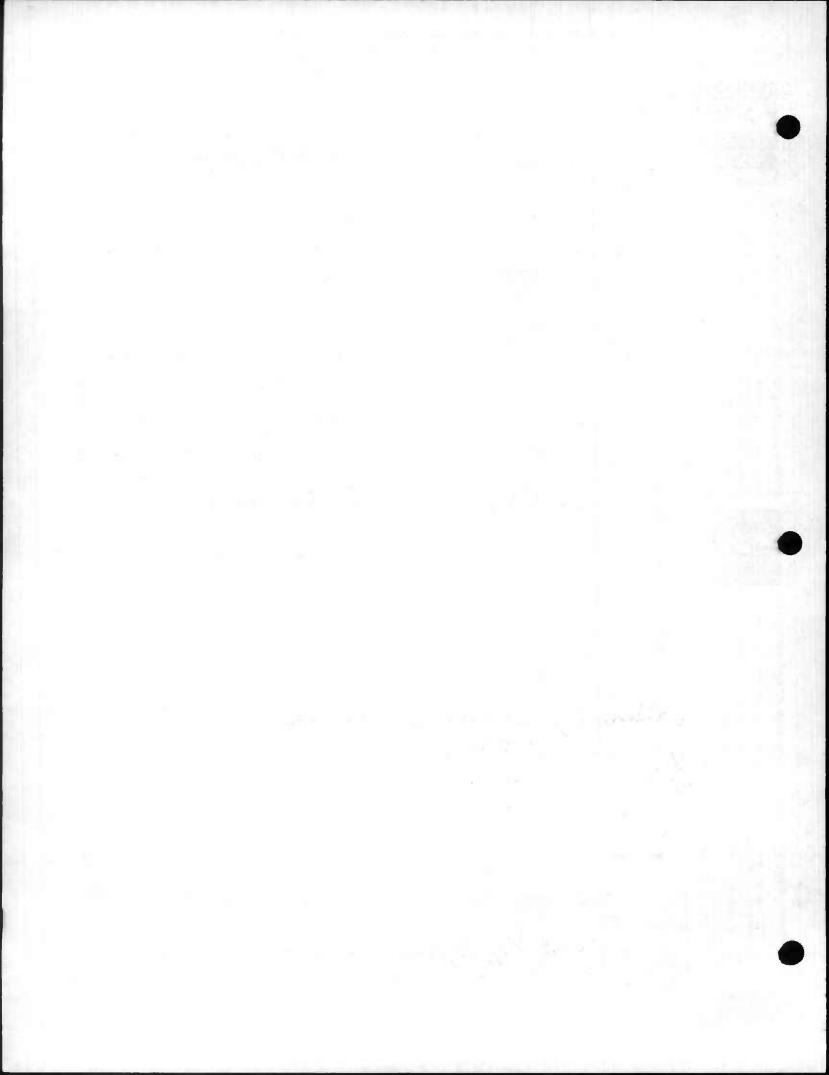
2 3 Wes casa referred to medical 1 Yes Mannar of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifiar 1 🖳 Certifying Physician: To tha best of my knowledge, daeth occurrad et the tima, data end place, and dua to tha cause(s) end menner es stetad.

2 Medical Exeminer: On the besis of exemination and/or investigetion, in my opinion, death occurred et the time, deta and place, and due to the cause(s) end manner steted. 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 1 untell Muan

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30. Neme end address of person who compl VAIRI MLHARL

32 Magistrate Signature Pandelle



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 1 per MD G-757 3/6/98 dh 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** DORGEY, SNOWDEN Snowden Dorsey 2:45 AM 1998 Feb /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Columbia If Under 1 Year If Under 24 Hrs. MD Hospital Howard 5. Social Security Number 8. Date of Birth (Month, Day, Year) NOVEMBER 12, 9. Birthplace (State or Foreign Country)
Maryland 6 Sex 7. Age (In yrs. lest birthdey) **Funeral** 1**√2**M 2□ F 89 Months Deys Hours Yrs. 1908 213-10-8883 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Howard County Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6336 Cedar Lane 21044 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 27000 If Yes, Give Year or Dates: 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White P **3**DWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Dacedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mentel Hygiene. ant: If item 27 Is marked other than ' ury or other traumatic event, the Me Elamentary/Secondary (0-12) Collaga (1-4or 5+) 12 farming poultry 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Be William Sheppard S. Dorsey Jessie W. (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. David Clarke/brother in law 9821 Cypressmede Drive, Ellicott City, MD 21042 20b. Place of Disposition (Neme of cemetery, cramatory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State XXX Buriel 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or page. Woodlawn Cemetery 18FEB98 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** fmmediate Causa (Final disease or condition resulting in death) /Medical Congestive heart failure Examiner Physician/Medical Examiner physician end s the burial-trensit The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to Immediate cause. Entar Underlying Cause (Disease or Injury that initieted eventa resulting in daath) Last Dua to (or as a consequenca of): Box 68760. Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by Paraesophageal hernia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, ð 24b. Wera autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy 1 Yes 200 No certificate 1 Yes 2 No Division of Vital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1º 1 Yes 2 No 1 pinpatient 2 ER/Outpatient 3 DOA s efter deeth.

I Director: After this ad in by the funeral d this 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Dascribe how Injury occurred 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital of within 24 hours e To the Funeral C completely filled Hospital edical 1 Decritying Physicien: To the best of my knowladga, daath occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifiar

29c. License number

D50338

11055 Little Paterment Pkny, Columbia MD

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifie

of person who complated cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** SR. Month 00 Daven port Edmun 1918 /Medical 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Mospital Baltimore Lemoria MA NIDA 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10M 20F Deys 219-38-612 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits na 23a or 28a-f shortman HIMORE 1 Tes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? STREET 21212 1531 OSA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, th and Mental Hygiene.
7 is marked other than "natural", or item traumatic event, or Medical Examiner. Bleck White etc. filed within 72 hours after 1 ☐ Yes 2 ☑ ★6 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1□ Yes 2 No þ 3 Widowed 4 Dolvorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sizabled 10+5 AG NA Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Pages 1 and 2 should be finent of Health and Mental int: if item 27 is marked of Russell Baven port Hattie N9a. fnformant's Name/Reletionship (Type, Print) 19b. Mailing Addressr(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health ar important: if item 27 is any injury or other trau DISTER 916 md Darbara Man Dalto 20b. Place of Disposition (Neme of cemetery, cremetory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremetion 3 □ Removal from State Randallstown, md 7-98 4 ☐ Donetion 5 ☐ Other (Specify) KINGMem. ar 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Home West Fre C. Marc 4300 Wabash Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. **Physician** /Medical tmmediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of) Physician/Medical Examiner Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) metrons Colon Due to (or as a consequence of): been signed by the a should be detached f Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24e. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? this certificate has ral director, page 2 1 Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Restdence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Ampatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Deetf 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending Investigation 1 Divatural 1 Yes 2 No 2 Accident ctor 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide edical Tag Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

2 Madical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier 100 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.W 30. Name end address of person who completed gause of death (Item 23e) (Type, Print) Hen

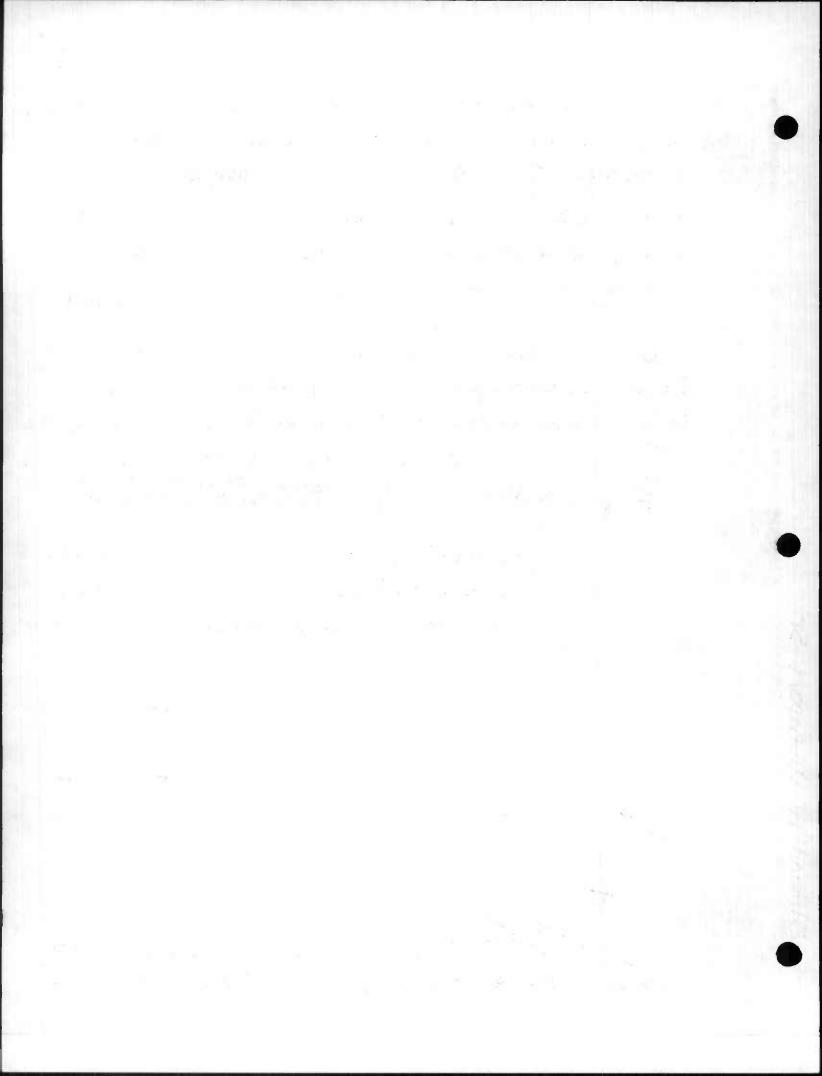
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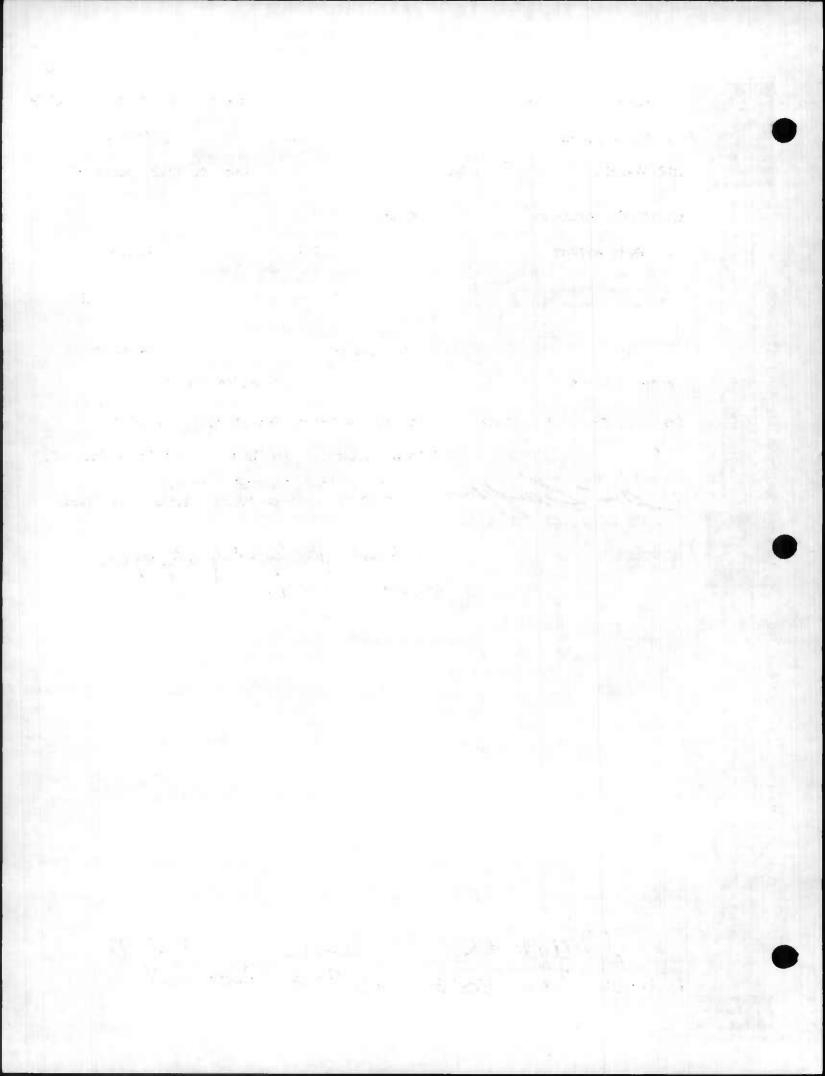
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month 3,1998 LOIS Α. FRANKLIN 0105 MARCH 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 8. Date of Birth Month, Day, Year) June 22,1931 5. Social Security Number If Under 1 Yaar if Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days Months Hours Min 1 □ M 2 1 F 229-32-4086 66 Yrs. Virginia Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Insida City Limits Md. Summerset 1 ☐ Yas 2 ☐ No Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7485 Catlin Road 21871 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2X☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Navar Married 2 ☐ Married 1 Yas 2XXNo Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Housewife own home 9th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Wolliam Hubbard Gladys Bryant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 8676 Doris Street Delmar Md. 21875 Barbara Beatty/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Garrison Forest VA Cemetery 3/6/98 Owings Mills MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensaa 22. Nama and Address of Facility Connelly Funeral Home of Essex polications that causad the death. Do not enter the mode of dying, such as cardiac or respirelony errest, one cause on each line. 23a. Part1. Enter the disease, or com-shock, or heart failure. List only Intervel Between Onset and Deeth PNEUMONIA Immediate Cause (Final 10 DAYS diseese or condition resulting in death) Due to (or es a consequence of) Due to (or es a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? UROSEPSIS 1 Yss 2 No 3 Probably 4 d Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

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Examiner

Physician/Medical

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Certification:

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7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Example; must be notified at

Hygiene.

the Maryland

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Division of Vital

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Director: After this certific

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Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Diseese or injury that initiated evants resulting in death) Lest

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 Pending investigation

6 Could not be determined

1 Yas 2 No

1 ☐ Yes 2 ☐ No

26. Piece of Death (Check only one)

Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work?

28a. Date of Injury (Month, Day Year) 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29b. Signatura and title of certifier 29c. Licansa number

Hospital:

D 46962 29d. Date signed (Month, Day, Year) MARCH 3, 1998.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. CHIRAZI. M.D. PENINSULA REGIONAL MEDICAL CENTER, MD 21801. MISHIRAZI, M.D.

State Registrar 31. Date filed (Month, Day, Year)

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 Naturel

3 Suicide

2 Accident

4 | Homicide

MAR 06 1998



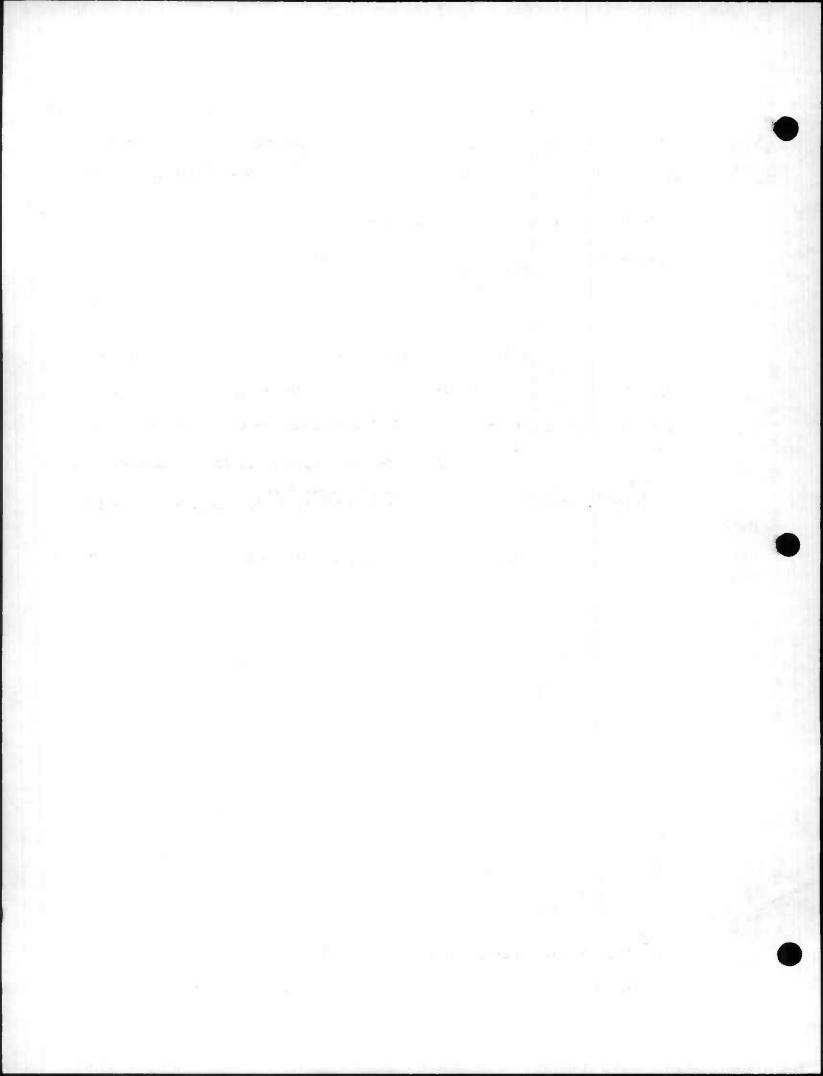
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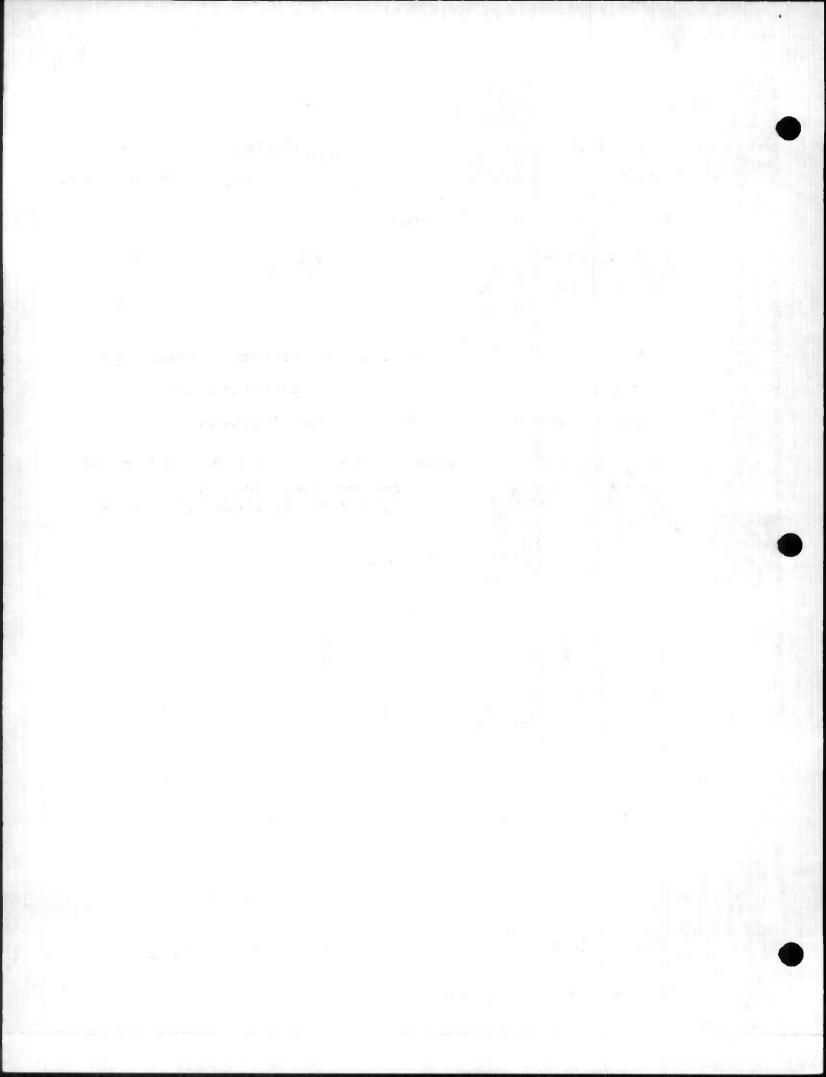
State of Maryland / Department of Health and Mental Hygiene

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Director 219-88-2799	7. Age (In yrs. 85	lest birthdey) Yrs.	If Under 1 Ye Months Da		Min.	Dete of Birtl (Month, De) rch 2	%, Yeer) 8,1912	Country)		
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				18. Mother	's Neme (Fi	irst, Middle,	Meiden Sumem	a)		
	Spaldin	g		Ber	nadet	te		Welty		
Martin 19e. Informent's Name/Reletionship (Type	e, Print)	19b. Meilir	ng Address (Str	eet end Number	or Rurel R	oute Numbe	r, City or Town,	Stete, Zip Co	de)	
Barbara Goldberg/Da	ughter	311	4 Sunse	t Lane,	Phoe	nix, 1	Maryland	2113	1	
Barbara Goldberg/Date 20e. Method of Disposition		Plece of Dispo	sition (Neme or	ple ce)		Date	20c. Location -	City or Town,	State	
20e. Method of Disposition 1 M Buriel 2 Cremetion 3 Rer 4 Donetion 5 Other (Specify) 21. Signature of Funerel Service Licensee	movel from State			·	dne 3	17/98	Timoni	um Me	rvlan	
21. Signature of Funerel Service Licensee				dress of Fecility		11750	LIMON	com y The	Death imore Birthplece (Steta or Focunity) Iaryland 10d. Inside City L 1 Yes 2 It Country? SA American Indien, White, etc. White ess/Industry Home elty te, Zip Code) 21131 y or Town, State m, Marylan 21093 Approximate Intervel Betwee Onset and Death TGARS TGARS Specify) or Rural Route Number of death? 1 Yes 2 No Specify) or Rural Route Number of death of the cause(s) Month, Dey, Yeer)	
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4 Homicide	4 ☐ Homicide determined determined 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)									
29a, Certifier 1 X Certifying Physic	cian: To the best of my kno	wtedge, deeth	occurred et the	e time, dete end by opinion, deeth	place, and	due to the o	cause(s) and me date end ptece, o	nner as atete	d. cause(s)	
The second of th	and manner steted.									
29b. Signature end title of certifier)			ensa number		1			, 1887)	
Where the	ruflet M	23	D3	3011			3-6	. 98		
30. Name and eddress of person who com	pleted suse of deeth (Iten	n 23e) (Type,								
Robert Wiedefeld	. MD 3346 P	apermi	11 Road	. Phoen	ix. M	arv1a	nd 2113	11		
State 31. Dete filed (Month, Day, Year) MAR 0.6 1999	32. Registrer's Signe				,	J				



				State	or Marylan		rtment of t tificate of		nd Mental Hy	gieney 8 Reg. No.	07121
	Physici	an	1. Decedent's Neme (First, Midd	le, Last)			1050	(- 10 L	2. Dete of De		3. Time of Deeth
N.	/Medic	cal	4e. Fecility Neme (If not institution	n give street end n	umber)	(- REC		MARC n, or Location of Deet	1011	998 2 p.m.
Ė	Funeral Director	ier	Good Samarit 5. Social Security Number 213-01-6103			lest birthday) Yrs.	If Under 1 Year Months Days	Balt If Under 24	imore Hrs. 8. Dete of Bir (Month, De	N	I/A 9. Birthplace (Stele or Foreign Country) Pennsylvania
	ylend		Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	y, Town or Loc	ation				10d. Inside City Limits
	Ba-1 st	ctor	MD N/	A	1	Baltimo	re				1 Yes 2 No
	with the	Funeral Director	10e. Street end Number 6008 Eunice	A.v.o			10f. Zip Code	1014		10g. Citizen of V	2011/1/
	deeth ms 23	nera	11. Marital Stetus	12. Wes De	cedent Ever in U	S. 13. W	es Decedent of	1214 Hispenic Origin	n? (Specify Yes or No	- 14. Rac	SA e - American Indian,
0000	72 hours after deeth with the Meryland natural', or items 23a or 28a-f show filted Examinet must be notified at	by	1 ☐ Never Married 2 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes. G	2 K) No Rive		☐ Yes 2X No		Puerto Rican, etc.)		k, White, etc. White
21215-0020	within ene. then	Completed		nt's Education st grade completed College	(1-4or 5+)		ent's Usual Occu ind of work done O NOT use retire istrativ				siness/industry
d 2	other of	Be Co	17. Fether's Neme (First, Middle,	Last)		ACIIIIII	ISLLALI	7-	SCAIIC s Name (First, Middle		Security 9)
Maryland	2 should be f and Mental I is marked of raumatic eve	To	John Kijows						olina Czlus		
Mai	end 2 sh saith and 1 27 is m er traum		19a. Informant's Neme/Reletions Edward M. Gi						or Rural Route Numb Baltimore		Stete, Zip Code)
Baltimore,	permit. Pages 1 er Department of Haa Important: If Item 2 any Injury or other		20a. Method of Disposition 1 Burlal 2 Cremetion 4 Donetion 5 Other (5		1 Stelle	lece of Dispos em <i>etery,</i> crem	ition (Neme of etory or other ple f Faith		Dete 3/5/98	20c. Location -	City or Town, State
altir	permit. F Departme Importan any Injur		21. Signature of Feneral Service	·	Gai	22.	Name end Addr				ore, MD
B	8258		A. George	alta	7	60	09 Harfo	ord Rd.	L HOME, P., , Baltimon	e, MD	21214
	Dhusialan		23a Part1 Enter the disease, o shock, or heert feilure. List	r complications the conly one ceuse on	eused the death each line.	h. Do not ente	r the mode of dy	ing, such es ce	erdiac or respiretory e	rrest,	Approximate Intervel Between Onset end Deeth
7	Physiclan /Medical		Immediate Ceuse (Final disease or condition	13 N	1=111	MON	TA				2 WEEKS
	Examiner	-	resulting in death)	011	Due to (o	r es a consequ	uence of):				THE WILLIAM
Т	uted d ansit	Examiner	Convention in the line and distance	b. —	Due to (o	r es e consequ	ience of):				
90,	licate be axecuted physician and s the buriel-transit	Exe	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury		500,00	. 00 0 00110040	101100 GIJ.				
68760,	ifficate be axecuted g physician and as the buriel-transit	edical	that Initiated events resulting in deeth) Lest	ŭ	Due to (o	es e consequ	ence of):	_			
Box	death certifi e ettending j ed for use as	an/M		d							
	0 0 2	Physician/M	Pert II. Other significant condition	ons contributing to	death but not res	ulting In the un	dertyling ceuse g	ven in Pert I.	23b. Did	tobacco use cor	ntribute to the cause of death?
, P.O	as thet thighed by	by Ph		LY	MPH	OM)	4		10	Yes 2 No	3 Probably 4 Unknown
Records,	requir been s should	Completed b							24a. Was	en eutopsy ormed?	24b. Were autopsy findings eveileble prior to completion of cause of death?
	The ate h	Com							1□	Yes 2 No	1 ☐ Yes 2 ☐ No
Vital	Physician: The this cartificate ral director, page	Be	25. Wes cese referred to medica examiner?	Hospital:			Ot	hor:	of Death (Check only		
O	Phys r this aral di	n: To	1 ☐ Yes 2⊠ No 27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of	3□ DOA 28c. Inju	4 □ Nurs	sing Home 5 Resi	dence 6 □Oth how Injury occur	
Division	Attend ctor:	edical Certification:	1 🖾 Neturel 5 🗆 Pendir 2 🗀 Accident investi 3 🗀 Sulcide 6 🗀 Could 4 🗀 Homiclde detern	getion not be 28e. Plea	e of Injury - At he	Injury ome, ferm, stre	M 1	Yes 2□No	28f. Location (Street and Numb	er or Rural Route Number,
ā		Cent		DUIK	ding, etc. (Specify	/) 			City or To	wn, 51616)	
	Pospital 724-hours Fundral Jetely ille	edica		Examiner: On the					place, end due to the occurred et the time,		enner es steted. end due to the cause(s)
	To the Within To the	M	29b. Signature end title of certifie	rhi, M	. 13.		29c. Licen	se number	0	29d. Date signer	d (Month, Dey, Year)
,			30. Name and eddress of person	who completed ceu	use of death (Item	23a) (Type, F		-			
	Sta	te	31. Dete filed (Month, Day, Year)	1771 7	013 LAC	HLAN	CIRCI	E	BALITM	ORE	M.N 21239
	Registr		MAR 06	1998 8	Mis David	ion-Mand	200				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, 2:45PM tion of Death 4b. City, Town, or Loca 4c. County of Death 4e Escility Neme (If not institution give stree LTIMORE If Under 1 Year 5. Social Security Number 2/5-32-/62 Usuat Residence of Decedent 9. Birthplace (State or Foreign Country) Days Months Hours 10b. County 10c. City, Toy 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married 1□ Yes 2□No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ONE 17. Father's Name (First, Middle, Last) 18. Mother's-Name (First, Middle, Maiden Surname Snow 19a. Informant's Name/Relationship (Type, Print) New 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandr MD. 2/2/17 Brown

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Med cal Exerciser must be notified at permit. Peges 1 and 2 should be filed within 72 hours effer death vigorement of Health and Mentel Hygiene.

Important: If fem 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Med as Exercise 2006. Completed 0

Physician

Examiner

Funeral

Director

with the Marylend

Baltimore, Maryland 21215-0020

/Medical

10a. State

Director

Funeral

by

Physician /Medical Examiner

ettending physician end for use es the buriel-transit been signed by should be detect entificate hes

The law requires that the death certificate be exec Aftending Physician: after dea Director 6 To the Hospital o within 24 hours at To the Funeral D completely

Examiner Division of Vital Records, P.O. Box 68760, Certification: To Medical

Physician/Medical þ Completed Be

State

Registrar

John 31. Date filed (Month, Day, Year)

25. Was cese referred to medical examiner?

29b. Signature and title of certified

MAR_06

5 Pending

Investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

t Matural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

Sharers Campneade Rd 518

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Methed of Disposition Burial 2 Cremation 3 Removel from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses BAUD. MO 21217 638 GILMOR 57 21a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart tailure. List only one ocuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting to death) a. RISPINATORY TO 24 Hms 10411 ALZIHI31 DILUS OU MUNIT Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Waknown

> 24b. Were autopsy findings avaitable prior to completion of ceuse of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Other: 4 Horsing Home 5 Residence 8 Other (Specify) 28c. Injury at Work? 28d. Describe how Injury occurred

1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

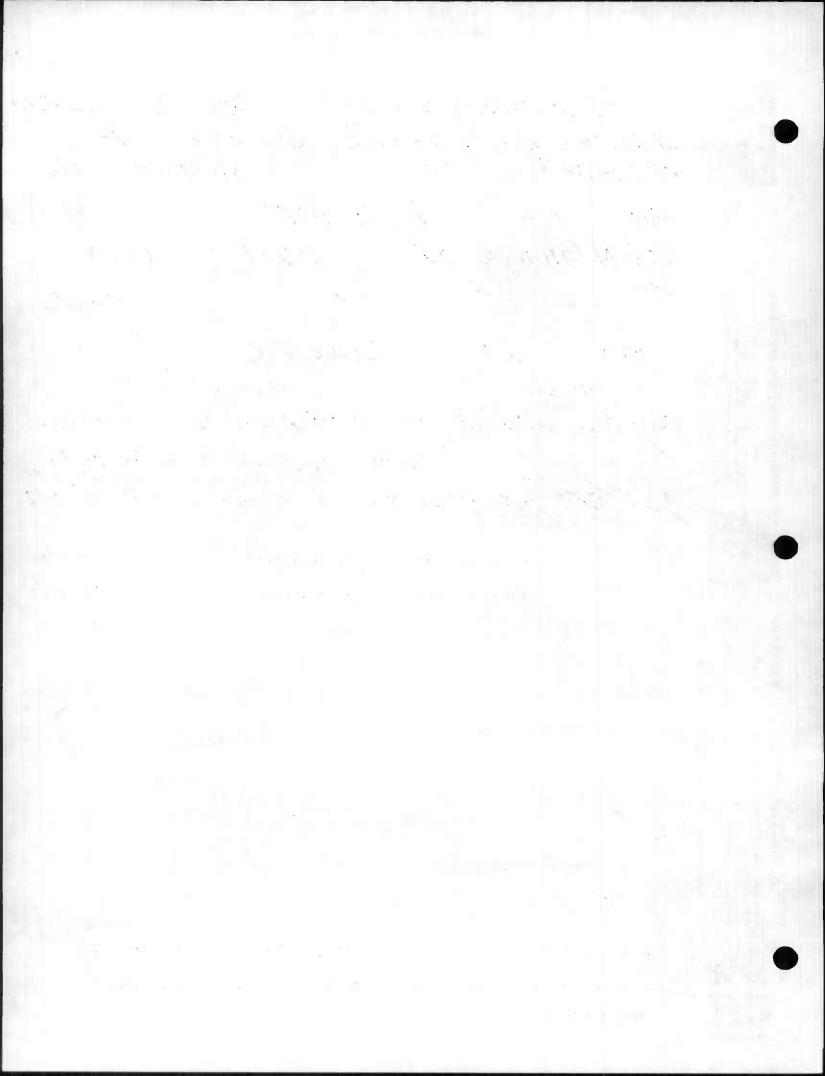
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

LinThicum, MD

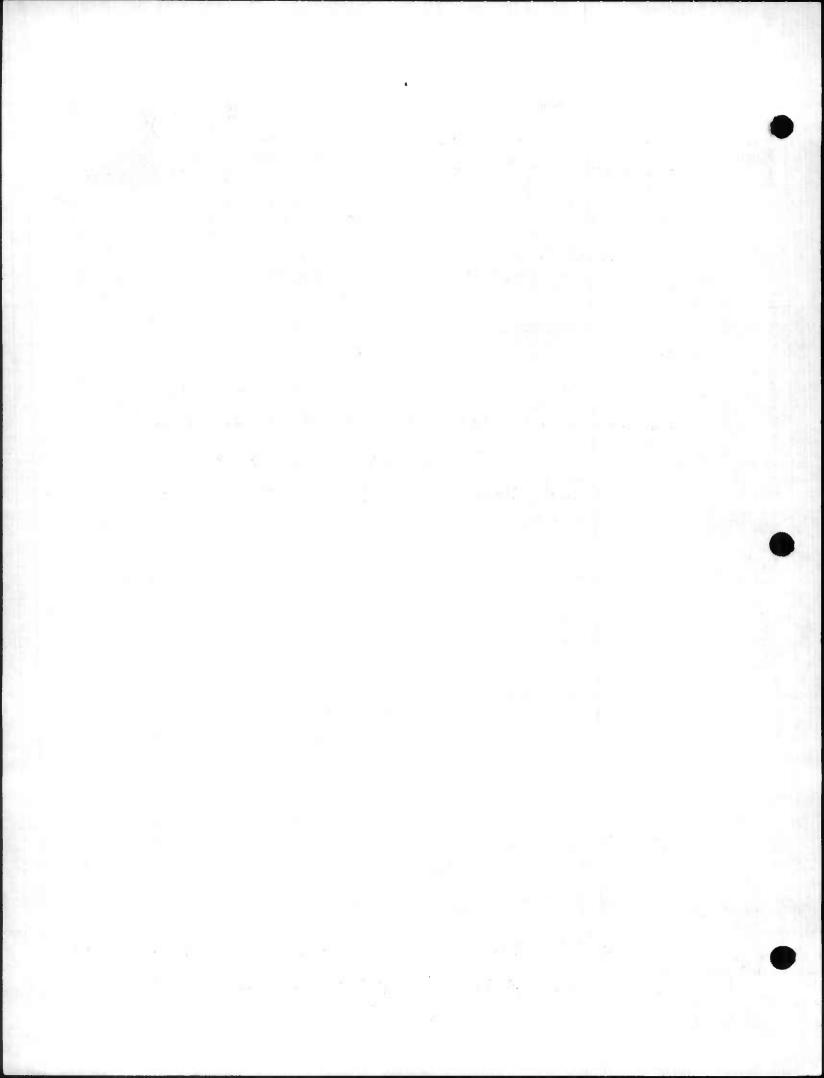
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death **Physician** Month Sarah R. Hock March /Medical non 4a. Fecliity Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mariner Health Care - Bel Air Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 9. Birthpiace (State or Foreign Country)
Maryland 8. Dete of Birth (Month, Day, Year) **Funeral** 1 M 2 F 87 Yrs. 213-44-8485 Director Usual Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Workest Examinar must be multial at Bel Air Maryland Harford 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? U.S.A. 21015 720 Burnside Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or their sny Injury or other treumatic event, the Medical Examination. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: specify: White à 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 12th grade Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maranto Nunzio Victoria Cardia 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Burnside Dr., Bel Air, MD Mrs. Jeanette Novak (dghtr) 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removei from State Most Holy Redeemer Cem. 3/7/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21236 Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final acute Myucardial Infunction

Due to (or as a consequence of): 5 minutes disease or condition resulting in death) Examiner ettending physician and I for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 VUnknown Dementin Alzheimere þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Director: After this certificate hes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospitel: 1 inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Naturei deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) To the Hospitat or Att within 24 hours effer d To the Funerel Direct completely filled in by 4 Homicide 15/Certifying Physictan: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.
21/D Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(a) and menner stated. 29a. Certifier (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34652 March 5, 1998 A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bil Air Mungland 21014 2 Nich Are Bel 32. Red states Standardson-Randala 2 Necth HASWELL 31. Date filed (Month, Day, Year) MAR 06 Registrar

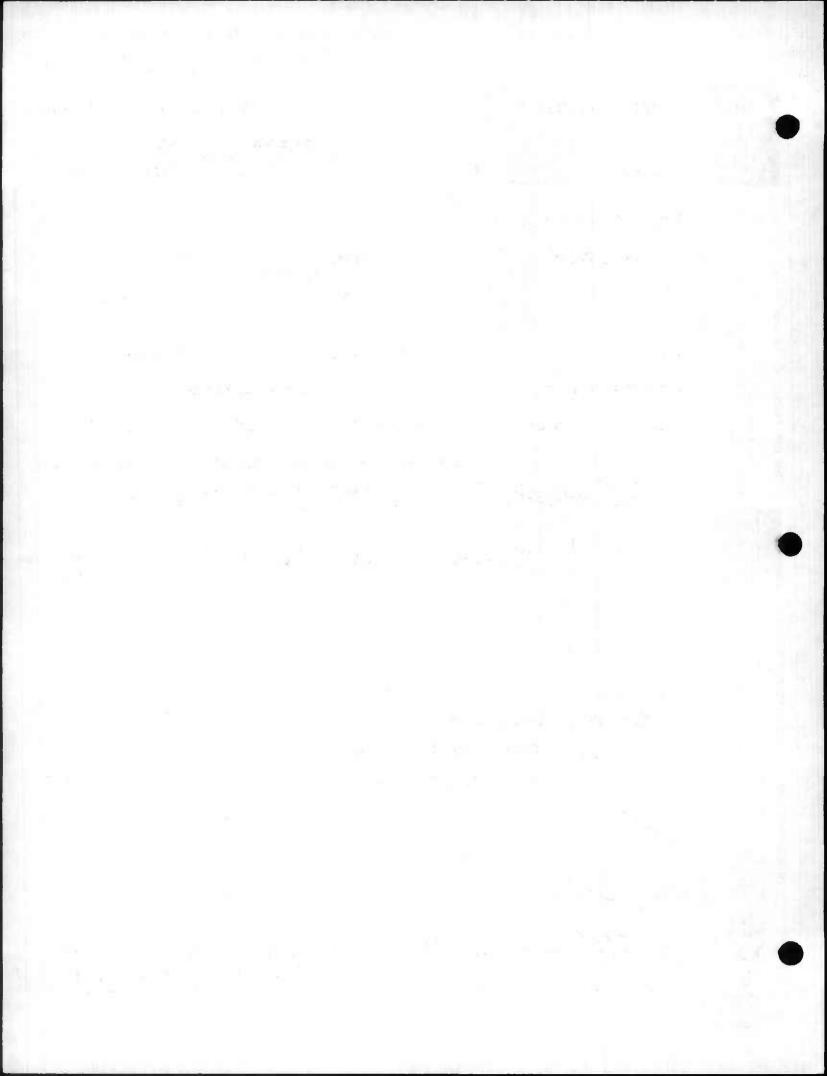


State of Maryland / Department of Health and Mental Hygiene 98

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month March 4, TERESA A. HELMINIAK 1998 9:30 p.m. /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 1023 Agate Drive Edgewood Harford If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth

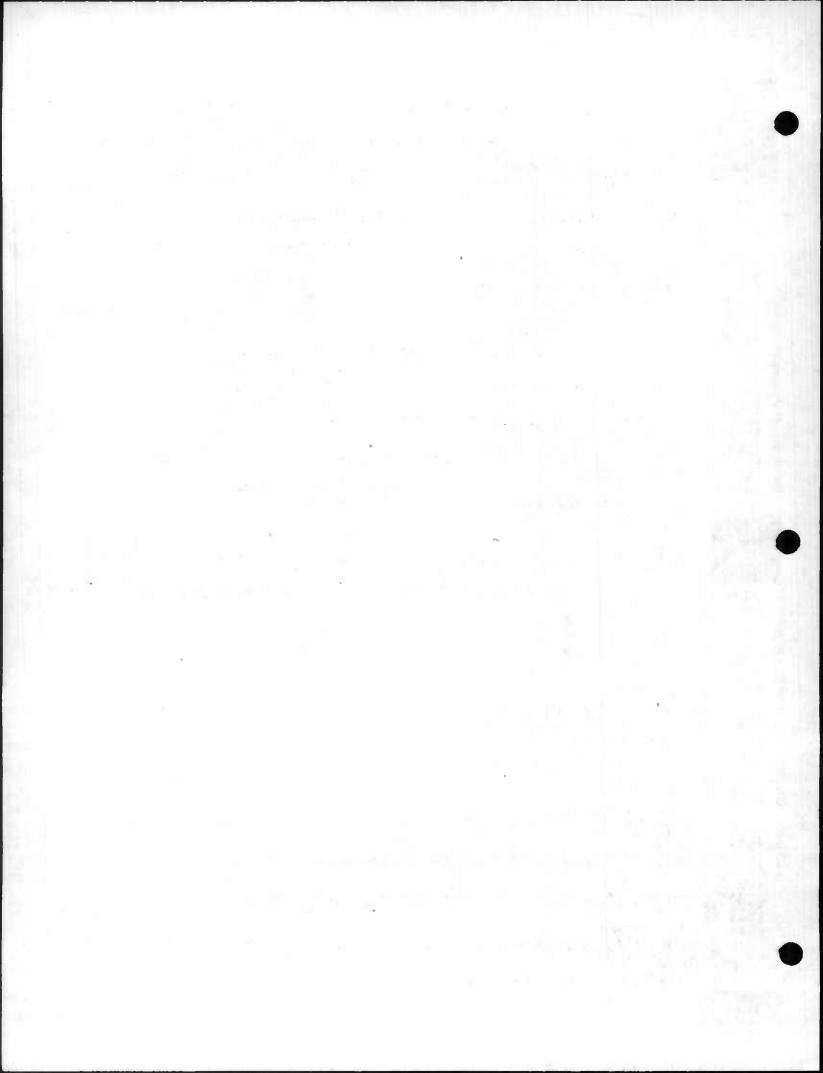
Month, Day, Year)

Jan. 31, 1909 Birthplece (State or Foreign Country) **Funeral** Days Months 1□ M 2X F 212-07-7919 89 Yrs. Director Maryland Usuai Residence of Decadent Pegas 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Haaith and Manial Hygiena.
Int: if item 27 is marked other than "natural", or items 23s or 28s4 show Lry or other traumstic avent, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Director 1 ☐ Yes 2 No Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1023 Agate Drive 21040 U.SA. by Funeral 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Busineas/Industry ementery/Secondary (0-12) College (1-4or 5+) 10th grade Office Worker Newspaper 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Vincent Helminiak Maryanna Pawlak 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Melonie Vogel (Niece) 1807 Hamlet Place, South, Bel Air, MD. 21015 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date permit. Pegas Depertment of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 3/6/98 Baltimore. Maryland 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21 21. Signature of Funeral Service Licensee 21014 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between **Physician** /Medical Immediate Ceuse (Final ereprovaschar disease or condition resulting in death) Examiner Physician/Medical Examiner sicien end burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last Due to (or es a consequença of): P.O. Box 68760. physicien the buria Due to (or as a consequence of): been signed by the ettending p should be detached for usa as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementio Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? Chronic Malnutrition page 2 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To this 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 1-Natural 5 Pending To the Hospital or Attending within 24 hours eftar daath.
 To the Funeral Diractor: Afte completely filled in by the fun 1 Tyes 2 No Investigetion 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homlcide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end menner as stated. (Check only one) 2 Madical Examinar: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print) MXPUEL HZATIL 31. Date filed (Month, Day, Year) 32. Receiver's Signature State lia Davidson Registrar MAR 06



State of Maryland / Department of Health and Mental Hygiene O

				, , , , , ,	Certifica		Death		eg. No.	b U	1/125
Physic	ian	1. Dacadent's Name (First, Middle, La	st)					2. Data of Daa Month		Yaar	3. Tima of Daath
/Medi	cal	(Sister) Mary 4a. Facility Name (If not institution, give			and, OS	P		03-04	1		2:30a.m
Exami	ner				/ 17011	,	4b. City, Town, or I		4c. County		
Funeral		Oblate Sisters 5. Social Security Number 6.5	SOI Prov Sex 7. Ag	Jideno ge (In yrs. last	t birthday) If Und	der 1 Yaar	Catons If Undar 24 Hrs.			1tim	
Director		220-58-1421 Usual Rasidanca of Dacedant	□ M 213 F	94	4 Yrs. Month	ns Days	Hours Min.	8. Data of Birth (Month, Day 0 7 - 25 -	Year) 03	Cour	laca (State or Foreign htry) MD
how		10a. Stata 10b. County		1	own or Location			<u>-</u>		1	0d. Insida City Limits
the Marylar 28a-f show	ctor	MD Baltin	nore	Bal	ltimore	(Ca	tonsvil	le)			1 Yas 2 No
23a or 2	Funeral Director	10e. Streat and Number 701 Gun Road		,		Zip Code 2122	27-3899	1	0g. Citizan of N USA	What Cour	itry?
n 72 hours after death with the Maryland "natural; or Hems 23a or 28a-f show coical Exercise man be notified at	by	11. Marital Status 1 ☑ Never Marriad 2 ☐ Marriad 3 ☐ Widowad 4 ☐ Divorced	12. Was Dacedant Armed Forces? 1 Yes 2 If If Yas, Giva Year or Dates:		1	cedant of I pecify Cub 2 No	Hispanic Origin? (Span, Mexicen, Puart Specify:	pecify Yas or No- o Rican, atc.)	Blad		
"netural",	etec	15. Decedant's Ed (Specify only highest gra	ducation de completed)	1	6a. Decedant's Us	suai Occup	pation during most of worked)	kina	16b. Kind of B		
	Completed	Elemantary/Secondary (0-12)	Collaga (1-4or !	5+)					Cab	1	
Hygi ther		17. Father's Name (First, Middle, Last)			Teach	er (Musicia	n) na (First, Middle, I	Sch		
	To Be	Arthur Lewis						Burkett		10)	
S D E E	F	19a. Informant's Name/Ralationship (1	19b. Meiling Addre	ass (Street	t and Number or Ru			State Zin	Code)
4.75 G		Sister M. Ale					un Road				21227-38
Pages 1 an ient of Haal nt: if Item 2 iry or other		20a. Mathod of Disposition 15€ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)			of Disposition (A etery, crematory of don Par			3-10-98	20c. Location -	City or To	wn, State
permit. Pa Departmen Important: any injury once.		21. Signetura of Funeral Service Licer			22. Neme Marc	end Addre	ess of Facility ineral H	ome Wes			
		23a Part Enter the disease, or com	elieations that caused	tha daath. D					nst,		Approximete Intervel Batwaan
Physician /Medical Examiner		Immadiata Causa (Final disaasa or condition rasulting in daath)	a Con	gest	five h	1	et fa				Onsat and Death 2 W KS
death certificate be executed e attending physician and ad for use as the bunal-transit	Aedical Examiner	Sequantially list conditions, if any, laading to immediata ceuse. Enfer Underlying Cause (Disease or Injury that Initiated avants	b. Ather	o Sch	a consequence of	Ca	rdo Vasc	culas Di	'seass		20 yrs
leath certificate attending phys if for use as the	n/Medic	rasulting in death) Last	d	Dua to (or as	a consequence of	():					
de atte	sicia	Part II. Other significant conditions co	ntributing to death be	at not resulting	n in the underlying	ceuca ah	van In Part i	23h Did to	henno use no	atelbuta to	the cause of death?
es that tha de igned by the a be detached (by Physician/	Complete				ceusa gn	ven in Part I.		a 2 No		ably 4 Unknown
aw requii 1s been s 2 should	Completed b	Carcinoma	4,01	tus	-			24a. Wes ar perform	autopsy ad?	ava	ra autopsy findings ilabla prior fo aplation of causa leath?
ate h	5	Viaco-Ci Ci	, acce	as				1□ Ye	s 210 No	1 🗆	Yas 2□ No
is certificate he director, page	Be	25. Wes cesa refarred to medicel exeminar?						th (Check only on			
r this certific	2	1□ Yas 2☑ No	Hospital: 1 ☐ Inpatie		Outpatient 3 🗆 🖸	OOA Oth	nar: 4 Nursing Ho	oma 5 Resida	nce 6 Oth	ar (Specify)
ctor. After thi	cation:	27. Manner of Death 1. Natural 5 Panding 2 Accident Invastigation	28a. Deta of Injur (Month, Day	Year) 28b	o. Time of Injury M	28c. Injur Wor	y at	28d. Dascribe ho	w injury occurr	ed	
15 to 15	Certific	3 Suicide 6 Could not be						28f. Location (Str City or Town	eet and Numbe State)	er or Rural	Route Number,
100	edical	29a. Cartifiar (Check only one) 1 Cartifying Phy 2 Madical Exam	sician: To the best o inar: On the basis of and mannar sta	examination a	ge, daath occurred and/or invastigatio	d at tha tin	na, date and place, pinion, deeth occur	and dua to tha ca red at the tima, da	usa(s) and ma ta and place, a	nnar as sta and dua to	atad. tha cause(s)
000	2	29b. Signature and tipe of certifier			29	9c. Licans	e number	29	d. Data signed	(Month, E	Day, Year)
	-	30 Name and address of	we			12	1649	1	Tareh	5,	1998
		30. Nama and address of person who con SAMBANDAM (BAS) 31. Data filed (Month, Day, Year)	ALAN, 3	455	Wilker	y h	VT Bal	timore	MO	212	29
Stat		31. Data filed (Month, Day, Year)	32 Registra	r's Signatura	0.0						



State of Maryland / Department of Health and Mental Hygiene 8

						Certif	ficate of	Death	F	leg. No.	UI	120)
	Physici	an	1. Decedent's Name (First, Middle, Les	it)					2. Dete of Dee Month	th Day	Yeer	3. Time of [Deeth
	/Medi		JAMES		HU	JMPHRE	CY		MARCH	5, 199		2:32	D.M.
	Examir		4e. Fecility Neme (If not institution, give	street end number)				4b. City, Town, or	Location of Death	4c. County			P-4.514.4
1			STELLA MARIS HOS	SPICE				TIMONII	UM	BALTI	MORE		
Т	Funerai		5. Sociel Security Number 6. Se	ex 7. Age	(In yrs. lest b		f Under 1 Year fonths Dev				9. Birthole	ece (State or	Foreign
8	Director		213-36-7614 Usuel Residence of Decedent	□ M 2□ F	58	Yrs.	fonths Dey:	s Hours Min.	4/8/39	, 1997)	NEW NEW	JERSE	Y
	yland Man		10a. State 10b. County		10c. City, To	wn or Locati	ion				10	d. Inside City	y Limits
	Mar I	tor	MD N/A		BAL!	TIMORE	E CITY					1X Yes	2 🗆 No
	1 the	Director	10e. Street end Number				10f. Zip Code		1	Og. Citizen of W	/het Count	ry?	
	3a o		3304 PARKLAWN AV	/ENLIE				21213		USA			
	death	era	11. Maritel Status	12. Wes Decedent E	ever in U,S.	13. Was		Hispenic Origin? (S ban, Mexican, Puer	Specify Yes or No-		a - America	n Indien.	
Maryland 21215-0020	n 72 hours effer death with the Maryland "natural", or items 23a or 28a-f show odcal Examinat must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorcad	Armed Forces? ↑ Yes 2 □ N If Yes, Give Year or Dates:	lo		es, specify Cu Yes 2X No		to Rican, etc.)	Specify Specify		tc. HITE	
0-10	in 72 ho	Completed	15. Decadent's Ed	ucation	166	e. Decedent	t's Usuei Occi	upation		16b. Kind of Bu			
218	G 3	ple	(Specify only highest gred Elementery/Secondery (0-12)	de completed) College (1-4or 5-	4)	(Give kind	d of work don NOT use retir	e during most of wo ed)	orking				
2	000	E O	12th GRADE	College (1-40) 5	*)	X-RAY	TECHN	ITCTAN-		X-RAY	REPA	TR	
b	be filed ntal Hygi d other event, b	Bec	17. Fether's Neme (First, Middle, Last)						me (First, Middle,			1111	
la	should be nd Mental marked o	TOE	MATTHEW HUMPHREY	7				CLADYS	S V. BUBE	3			
ary	E B B B		19e. Informent's Name/Relationship (7	ype, Print)	19	b. Mailing A	Address (Stree	et end Number or R			Stete, Zip (Code)	
	1 end 2 Health a em 27 ls		BETTY J. BOWERS	SIS	TER 3	1705 W	VAYNE A	VENTIE B	ALTIMORE	MD 21	234		
Baltimore,			20a. Method of Disposition	0,0	20b. Piece	of Disposition	on (Neme of			20c. Location -		n, Stete	
9	age ent o ht: If y or		1 ■ Buriai 2 □ Cremation 3 □ I				ory or other pi	1	2 /0 /00	*****		MD	
	artmortan ortan Injur		21. Signeture of Funeral Service Licens		MORE			AL PARK	3/9/98	HILLEND	ALE,	MD	
Ba	permit. Pages Department of Important: If it any Injury or once.		N/ 11 1	/				UNERAL HO	OME, P.A.				
G			frenthe N.	Hays		852	21 LOCH	RAVEN BI	LVD. TOW	SON, ME			
П			23a. Part1. Enter the disease, or comp shock, or heert feilure. List only of	ne ceuse on each lin	the death. Do e.	not enter th	he mode of dy	ring, such es cardie	c or respiretory err	est,		Approximete Intervei Betw	veen
	Physician /Medicai Examiner		Immediate Ceuse (Finel disease or condition resulting in deeth)	Polor	Ca	ncla						Onset end De	eam
		ner	resulting in deedily	1	Due to (or es e	consequer	nce of):						
	certificate be executed rding physician and use es the buhal-transit	Examiner	Sequentially list conditions, if any, leading to immediate	b	Due to (or es e	consequen	nce of):						
68760,	A Ca		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury	c									
387	physicate sthe	edicai	thet initieted events resulting in death) Lest		Due to (or es e	consequen	ice of):				i		
	ding ph	Σ		d									
Box	deeth cei le ettendir ed for use	lan											
Ö	0 0 0	Physician/	Pert II. Other eignificent conditions co	ntributing to death bu	t not resulting	in the under	rlying cause g	iven in Pert I.	23b. Dld to	obacco uee con	tribute to 1	the cause of	f death?
<u> </u>	es that the deeth ce igned by the ettend be detached for us	by Ph							1 🗆 Y	es 2□ No	3 Probe	ibly 4	Onknown
of Vital Records,	been s	Completed							24a. Wes e perfor	en eutopsy med?	avei	e autopsy fin leble prior to pietion of ca seth?	
r	0 - 0	Om							1 🗆 Y	es 2 000	1 🗆	Yes 2 N	No
<u>ra</u>	iclan: Th certificata rector, pa	Be C	25. Wes case referred to medical					28 Place of Dec	eth (Check only or				
>	Physician: this certific ral director,	ToB	exeminer? 1 \(\text{Yes} 2 \text{\$\mathcal{O}} \text{No} \)	Hospital: 1 ☐ Inpetier	nt 2 ER/O	outpetient :	3 DOA O		dome 5 ☐ Reside		r (Specify)	HOSPI	ICE
DIVISION OF	il or Attending Phys after death. Director: After this d in by the funeral d	Certification: 7	27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28e. Dete of Injun (Month, Dey		Time of Injury	28c. Inj		28d. Describe h			HODI I	LOE
ZIS	r dea	fice	3 Suicide 6 Could not be	28e. Pieca of Inju	ry - At home, f	arm, street.	fectory, office		28f. Location (S		er or Rural	Route Numb	00r,
S	afte Dir din t	ert	4 Homicide	City or Town	n, Stete)								
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier (Check only one) Exami	elcian: To the best of lner: On the besis of end manner stat	examinetion e	e, deeth oc nd/or Invest	curred et the igation, in my	time, dete end plece opinion, death occu	e, end due to the curred et the time, d	euse(s) end me ete end pieca, e	nner es ste and due to t	ted. the ceuse(s)	
	To the within 2 To the comple	29b. Signature and the properties of certifier 29c. License number						ise number	2	9d. Date signed	(Month. D	ey, Yeer)	
	F3F8		1 Jehr	es as				15504		3 5 9		-,,	
	. 21												
	1011		30. Name end eddress of person who c				•						
	1		DR. EDDIE NAKHU 31. Date filed (Month, Dey, Year)		DULANES	Y VALI	EY RD.	TIMONIU	JM, MD 21	.093			_
	Sta Registr		MAD 0 6 1000	32. Registre	rs Signeture	anda 00							

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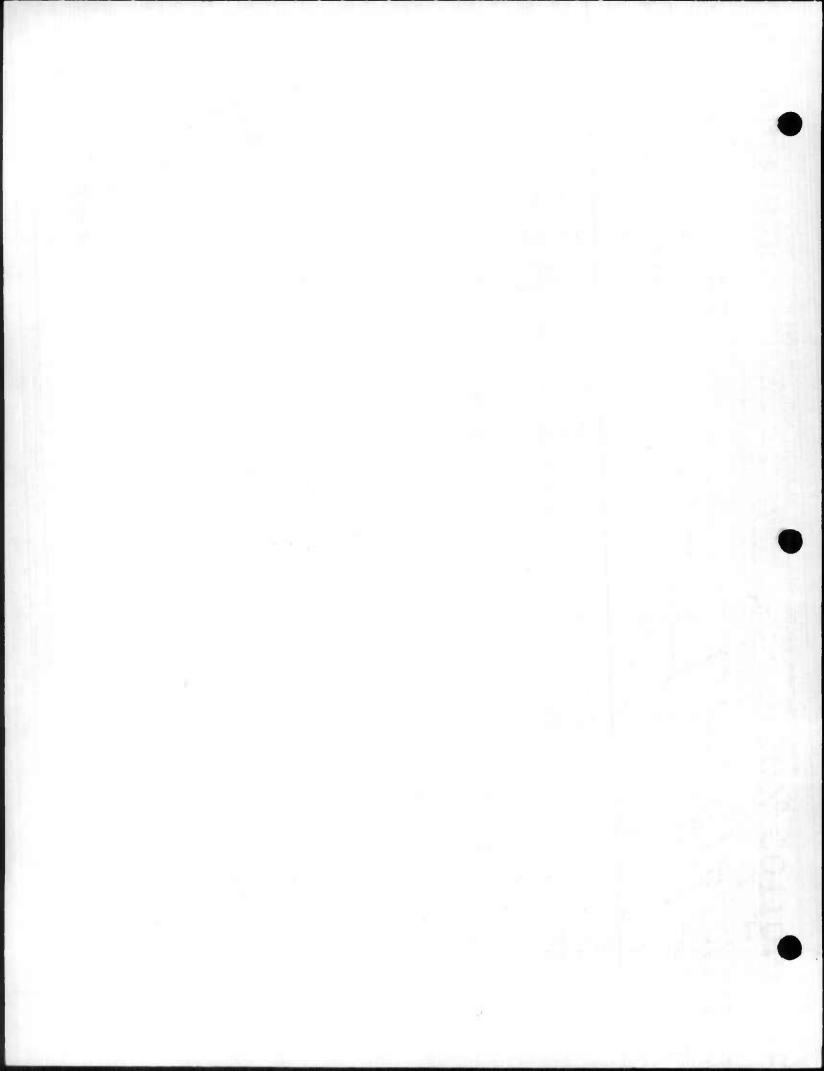
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certification personal and within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician has been signed by the attending physician has been signed by the attending physician has been signed by the attending physician has been signed by the attending physician has been signed by the attending physician has been signed by the attending physician has been signed by the attending physician has been signed by the attending physician has been signed by the attending physician has been signed by the attending physician has been signed by the attending physician has been signed by the attending physician by the attending physician has been signed

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumale event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFICA	ATE OF	DEATH	REG	NO.	
	1. DECEDENT'S NAME (First, Middle, Last)	Haug	Nt		10	2. DATE OF OEAR	TH DAY	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. S.	EX 6. AGE (1		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Day, Ye	7,1932	BIRTHPLACE (State or Foreign
TOR	90. FACILITY NAME (II not institution, give street a CROWUELL M RESIDENCE OF DECEDENT	nd number) URSING +	bine of	CITY, TOWN OF	SOIU	ATH	Sc. COUNT	HTMORE
DIRECTOR	109. STATE 109. COUNTY	vore		UN3 DO				10d, INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	10s. STREET AND NUMBER	G- Gurt			ZIP CODE 21227)	10g. CITIZI	EN OF WHAT COUNTRY?
BY FUN	1 Never Merried 2 Merried	WAS DECEDENT EVER IN FORCES? 1 _ YES IF YES, GIVE WAR OR DA	2-NO		NOENT OF HISPAN city Cuben, Mexices Specify	n, Puerto Ricen, et		14. RACE — American Indian, Black, White, atc. Specific Units
COMPLETED	15, OECEDENT'S EOUCATIO (Specify only highest grade comp Elementary/Secondary (0-12)	N leted) llege (1-4 or 5+)	18a. DECEDENT'S USU (Give kind of work life. Do NOT use re	done during most	of working	_	F BUSINESS/INDU	1 '
MP	G A)	CHO L) MIO E				1.1077
BE CO	00010111	ICICNE			18. MOTHER'S NAI	ARID	D' AL	m1 CO
10	1997 NFORMANT'S NAME (TYPO/Print) DEBOIE EDER		196. MAILING AD	11 1	d Number or Aurel F	laco 13	or Town, State, Zip (mol. 21227
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Removal 1 4 Donation 6 Other (Specify)	from State 20b.	PLACE OF DISPOSITION PLACE OF	remotor	4 Inc	. 1	74	Went ferd.
	21. SIGNATURE OF FUNERAL SERVICE LICENSE	Dool		1211	CHESA BOLLUM	co Apre		21737
	23. PART I. Enter the diseases, or comp shock, or heart failure. List							Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Diah	etes	W	ellitu	4		Onset and Death
		DUE TO (OR AS A	CONSEQUENCE OF):	NIO	phro	neith	V	
ON	Sequentielly list conditions, if any, leeding to immediate	OUE TO (OR AS A	CONSEQUENCE OF):	14	131111	Pec	7	
CAT	cause. Enter UNDERLYING CAUSE (Disease or injury							
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
	PART II. Other significant conditions co	ntributing to deeth b	ut not resulting in t	he underlying	cause given in		AS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
EDICAL	HX OF 13re	east C	NADWIO				ERFORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	Hypothy	wilpon				_		1 - YES 2 - NO
N.	25. WAS CASE REFERRED TO MEDICAL	0		0.2				
C	EXAMINER? HO	SPITAL:		THER:	ACE OF DEATH (Ch	97		
PHYSICIAN: M	27. MANNER OF OEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJU			NOW INJURY OCC	URED
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicide datermined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, streetly)	st, factory, office		261. LOCATION (City or Town,		or Rural Route Number,
COMPLETED	(Check only	: To the best of my known the bests of examination						od. o cause(e) and manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	and the second	Siasmi	AFO	29c. LICENSE NUI	MBER 901	29d. DATE	SIGNED (Month, Day, Year)
10	30. NAME AND ADDRESS OF PERSON WHO CO		ATH (ITEM 27) (Type, Pri	Salt.	more,	WO ?	2/2/4	
	31. DATE FILED (Month, Day, Year)	12. REGISTRAR'S SIGN						
	MAR 0 6 1998	TOTAL PROPERTY	4					



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth MARCH 1998 HENRY HUGEL 9:24 AM 4a Fecility Name (If not institution, give street end number)
Saint Joseph Medical 4b. City, Town, or Location of Deeth 4c. County of Death Center Baltimore Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex 8. Dete of Birth (Month, Dey, Year) Days 12 M 2 F 218 - 03 - 58558 2 DEC 10 1915 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a Stete 10b. County 1 ☐ Yes 2 ☑ No BALTIMORE CO. MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2526 HILLCREST AVENUE 21234 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck. White, etc. 1 ☐ Never Married 2 ☑ Married Specify: WHITE 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind ot Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) MECHANIC TIRE CO. 8 th
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) HARRY HUGEL MARY KOLB 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) JENNIE H. HUGEL/ WIFE 2526 HILLCREST AVE., BALTIMORE, MD. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Dete 20c. Location - City or Town, Stete cemetery, cremetory or other plece) 1 Burial 2 ☐ Cremation 3 ☐ Removel from State MORELAND MEMORIAL 3/7/98 BALTIMORE 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Facility 21. Signet of Funeral Service Licensee HARTLEY MILLER FUNERAL HOME elle 11 Enths the disease, of complications that caused the deeth. Do not enter the node of toying, such as Dardies Dr respiratory Larte Q. • MD • 2 1 2 3 oproximete interval Between const. or heart failure. List only one ceuse on each line. RESPIRATORY FAILURE 1 HOUR Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence ot) SUSPECTED SEPSIS Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence ot) HYPERTENSIUN Due to (or es e consequence ot) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CEREBRALVASCULAR ACCIDENT 24b. Were eutopsy tindings evailable prior to 24e. Wes en eutopsy PEMENTIA completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Deeth (Check only one)

Physician /Medical Examiner Examiner the death cartificate be executed

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

MD

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Modical Examinar mast be notified at

Hygiana.

Pagas 1 and 2 should be filed w inent of Haalth and Mental Hygian lant: If item 27 is marked other thoury or other traumatic avent, in

permit. Paga Department o Important: If any Injury or

with the Maryland

death

filed within 72 hours after

Maryland 21215-0020

Baltimore.

P.O. Box 68760.

Records,

Bivision of Vital anding Physician:

eath.

8

physician and s the burial-transit use as 0 signed by the a page 2 s has cartificata director, this funarai Aftar

Physician/Medical

þ

Completed

Be

2

Certification:

edicai

25. Wes case reterred to medical Hospital: 1 I Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 5 Pending injury 1 Neturei 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28t. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one)

2 ■ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. I Icense number

29b. Signeture end title of cartiller

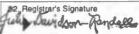
29d. Date aloned (Month, Dev. Year) 98

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

SHOAIB A. HASHMI. M.D., 3400 ERDMAN AVENUE BALTIMORE, MARYLAND 21213

State Registrar

31. Date tiled (Month, Dey, Year) MAR 0 5 1998



MI)

No. of the latest property.

Torre Torre

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ohnson Wilson tenry OUp.m 90 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore Under 24 Hrs. 8. Date of Month outher ve. 5. Social Security Number If Under 1 Year Months Days 7. Age (In yrs. lest birthdey) 6. Sex Birthplace (State or Foreign Country) 102M 2□ F Days Hours 228-01-81 Rich moud VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 1 468 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 S ern 12. Was Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Stetus 14. Rece - American Indian, Bieck, White, etc. 1 NYes 2 No. If Yes, Give 5/1/4/∞ 1 ☐ Never Married 2 ☐ Married 1□ Yes 2☑1No 3 DWidowed 4 □ Divorced 190 10-21-44 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ware houseman 12th Grade relephone 17_Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Henry arion 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Ind. 21215 ete 20c. Location - City or Town, State 5112 Ka. arolyn 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) Dete 1 Buriel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Vot. Cem 21. Signature of Funeral Service Licensee Home 302 ocks Tuneval Part 1. Enter the disease, or complications that caused the shock, or heart failure. LISI only one cause on each line. eeth. Do not enter the mode of dylng, such es cardiac or respiratory arrest Approximate Interval Between Onsel end Death Immediate Cause (Finel disease or condition resulting in death) Due to (or es e consequence of): Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2□ No 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Attending Physician: The law requires that tha death certificete be axecuted

signed by the

been

this certificete

Asi Director: After this lied in by the funeral

Funa

within 35

death.

or A

page 2 should be

10

edical Certification:

P.O. Box 68760.

Records,

Division of Vital

Department of Health e Important: If Item 27 is any injury or other trains

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

2

Funeral

Director

Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland nent of Health end Mental Hygiena.

ant: If Item 27 is marked other than "natural; or items 23a or 28a-f show ury or other traumatic event, if a Medical Examinal must be not fed at

Maryland 21215-0020

Baltimore,

Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Physician/Medical þ Be Completed

26. Place of Death (Check only one)

25.		referred to	medical
	examiner?		
	1 ☐ Yes	2 X No	

5 Pending investigation

6 Could not be

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 28c. Injury at Work? 1 Tyes 2 □ No

Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one

27. Menner of Death

Natural

2 Accident 3 Suicide

4 Homicide

Sertifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated.

5601

29b. Signature end tiffe of certifier

29c. License number 38403 29d. Date signed (Month, Dey, Yeer)

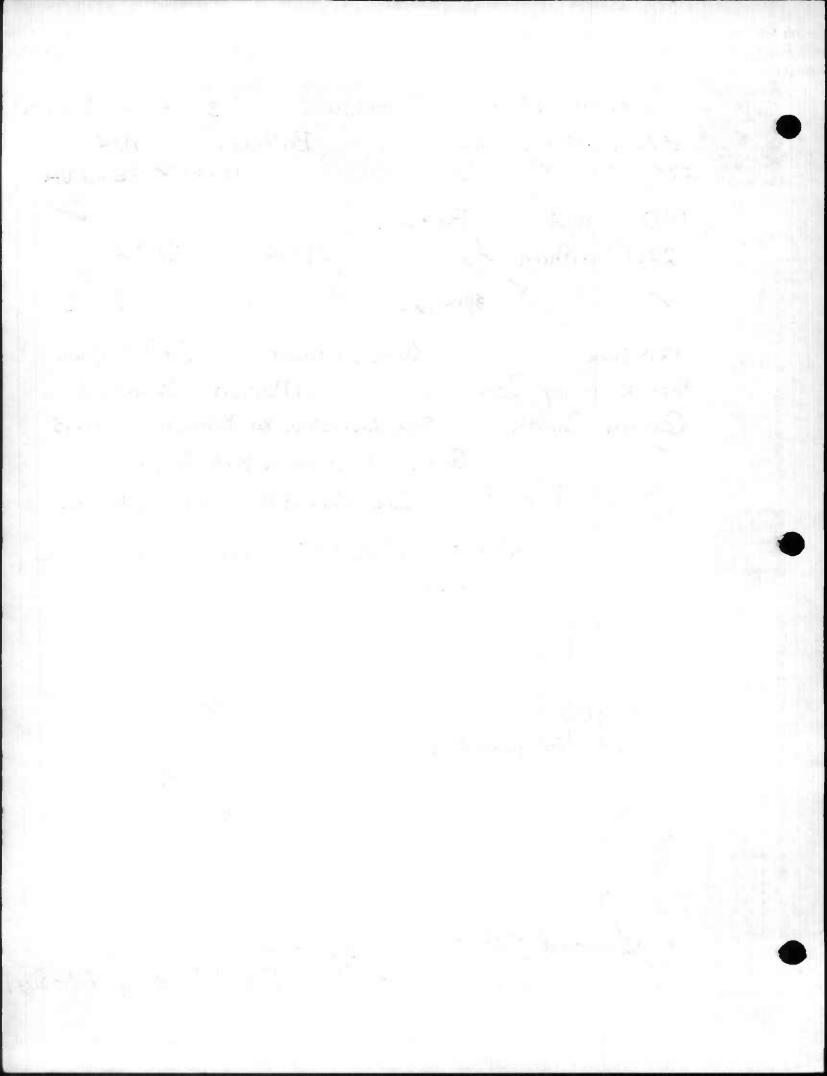
30. Name and address of person

ause of deeth (Item 23a) (Type, Print) GOOD SAMARITAN HOSP.

Loch

State Registrar

and 31. Date filed (Month, Day, Year) MAR 0 6 -0 1998

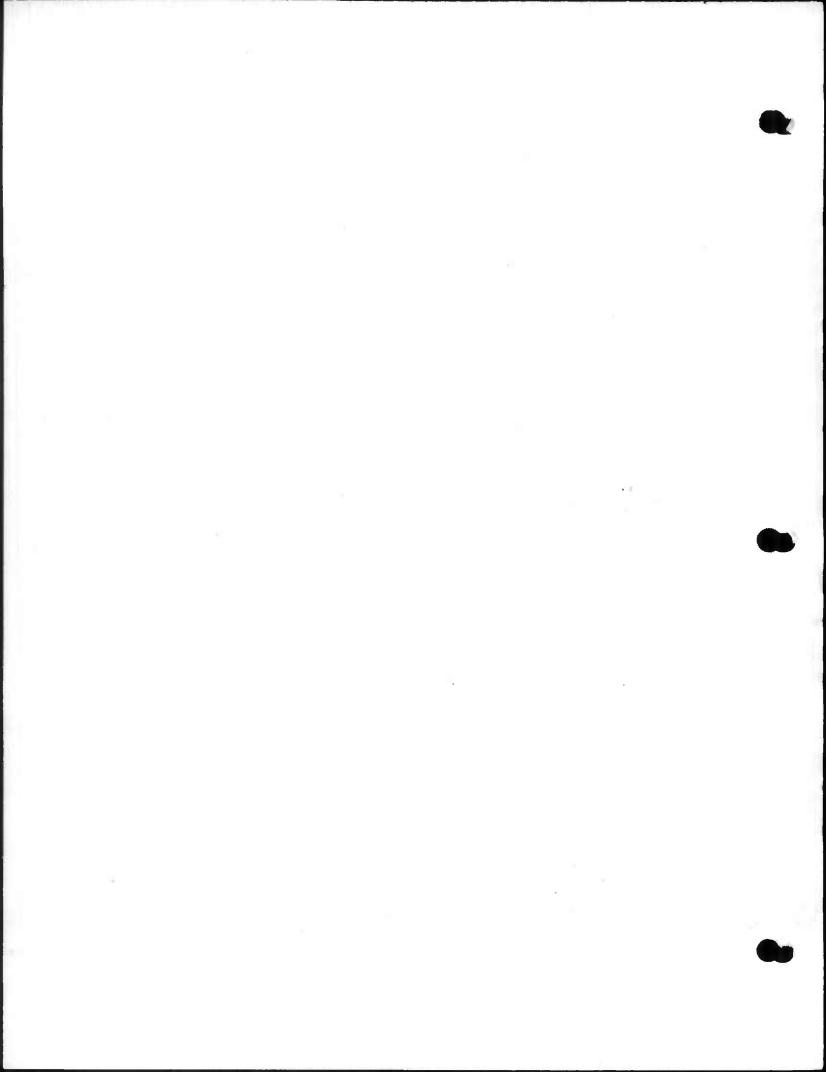


the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate to provide the property of the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to be filled in completely filled in the state Dept.	MPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The	TO THE FUNERAL DIRECTOR: After this certificate his be filed within 72 hours after death with the State D	IMPORTANT: It item 28 is marked, or item	

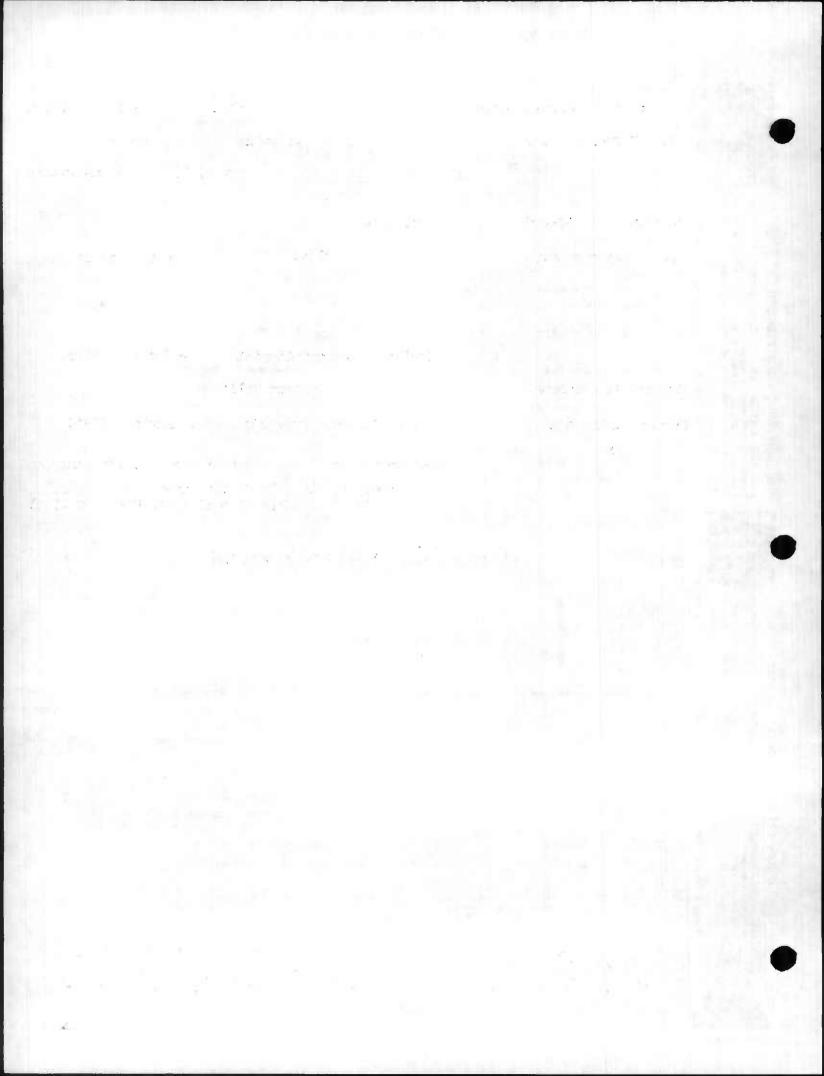
	FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPART			MENTAL HYGIE!		
	1. DECEDENT'S NAME (First, Middle, Last) Belowy	iones				2. DATE OF DEATH MONTH	DAY Y	3. TIME OF DEATH
			rrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	6.	BIRTHPLACE (State or Foreign
		K⊠M2□F 64	YRS.	ONTHS DAYS	HOURS MIN.	(Morith, Day, Year) 05-13-33		Md
NG.	9a. FACILITY NAME (II not institution, give stree North Charles F			Balti	MOLE	EATH	9c. COUNTY	OF DEATH
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		40° CITY	TOWN OR LOCAT	TON!		1	1
DIRECTOR	Md. NA			ltimor				10d. INSIDE CITY X LIMITS? YES 2 \(\text{NO} \) NO
FUNERAL	10e. STREET AND NUMBER				ZIP CODE			OF WHAT COUNTRY?
JNE	2443 Guilford	AVENUE 12. WAS DECEDENT EVER IN U.	S. ARMED		1218	HC ORIGIN? (Specify Ye	USA	RACE — American Indian,
BY FI	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYES	2 NO	if yes, sp	2 NO Specify	n, Puarto Rican, atc.)	10.110	Black, Whita, atc. Specify:
	15. DECEDENT'S EDUCAT		MY Se. DECEDENT'S U					Black
COMPLETED	(Specify only highest grade co.	college (1-4 or 5+)	(Give kind of wo life. Do NOT use	rk done during mo retired.)	st of working	16b. KIND OF BU	SINESS/INDUS	TRY
MPL	High School	NA	Contr	uction	worke	er Const	ructi	on Co.
8	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Malder		Smith
8	Landy Jone 19a. INFORMANT'S NAME (Type/Print)	<u> </u>	T 105 MAIL INC A	ODDEGO (Over-1	Glady	7 S Route Number, City or Tox		
2	Lisa Squa	ire			eson St			Maryland
	20a. METHOD OF DISPOSITION 1 ★ Burlal 2 □ Cremation 3 □ Ramova 4 □ Donation 5 □ Other (Specify)	al from State cemete	ACE AND DATE OF ry, crematory or other	er place)				or Town, State Md.
	21. SIGNATURE OF FUNERAL SERVICE LICEN		rrison	Eores 22. NAME AN	T VA CE	om. O.K-O(1-98 C	wings Mills, Maryland
	J. Valence	2 Holla	Q.	WM.C	. March	n FH 110	l E. N	Natyrand North Avenue
	23. PART I. Entar tha diseasea, or cor shock, or haart failure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	st only ona cause on aach	ne death. Do no n lina.			h aa cardiac or reap	iratory arreat	Approximata interval Batween Onset and Death
		DUE TO (OR AS A CO						
CERTIFICATION	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A CO	ONSEQUENCE OF):					
	cause, Entar UNDERLYING CAUSE (Disease or injury that initiated eventa	DUE TO (OR AS A CO	ONSEQUENCE OF:					
	resulting in daeth) LAST							
	PART II. Other significant conditions	contributing to death but	not reaulting in	the underlying	cause given in	Part I. 24a. WAS AI	AUTOPSY	24b. WERE AUTOPSY FINDINGS
MEDICAL		the liver				PERFO		AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
ME						_		1 - YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL				UNCERTAI	V E		
SICI	EXAMINER?	HOSPITAL: Inpatient 2 ER/Outpatie		OTHER:				
ΉÝ	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 26c, INJ	URY AT	6 Other (Specify) 28d. OESCRIBE HOW	INJURY OCCUR	ED
ВУБ	1 Natural 5 Pending 2 Accident Investigation		INJUI	M 1 . 1	RK? /ES 2 NO			
COMPLETED	3 Suicide 6 Could not be determined	28a. PLACE OF INJURY — building, etc. (Specify)	At home, farm, str	eel, factory, offic.		281. LOCATION (Street City or Town, State		Rural Route Number,
PLE	29a. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my knowled	ge, death occurred	at the time, data	and place, and due	to the cause(a) and ma	nner as stated.	
NO.		On the basis of examination er						ause(a) and manner es stated.
BE C	29b. SIGNATING AND TITLE OF GENTIFIER				29c. LICENSE NUM	ABER	29d. DATE SI	GNED (Month, Day, Year)
2	38. HAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEATH	(ITEM 27) /See 5	Print)	1)27	565	31	2/44
	//4/ 1////	ney 183.		eere	Tree	Vld -	# 3=0	
	31. DATE FILED MORE ON THE TOTAL TOT	32. REGISTRAR'S SIGNATE	me Ganda &	2				



State of Maryland / Department of Health and Mental Hygiene 9 8 07 13 1

						Certif	icate of	Death		R	eg. No.) U	1131
			1. Decedent's Name (First, Middle, Las	t)						2. Data of Dear	th	Vans	3. Time of Death
	Physicia	_	Barbara W. Ju	rkscheit						March	Day 4	998	3:00am
	/Medica Examine	_	4a Facility Name (If not Institution, give	straet and number)				4b. City, Tov	vn, or Lo	ocation of Death	4c. Count	y of Death	- Balling
7	LAdillille	Т	5114 Hesperus Dri	.ve				Col	umb	ia	Н	oward	ł
	Funeral Director		5. Social Security Number 6. S 174~24-7895	ex	n yrs. last bir		Under 1 Year onths Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day NOV 5,	1931	9. Birthi Cour Pen	place (State or Foreign intry) insylvania
	D.		Usual Residence of Decedent	14/	o Cir. Terr								40d Incide City Limits
	aryla		10a. State 10b. County		C. City, Tow								10d. Insida City Limits 1 ☐ Yes 2 ☑ No
	M es	2	Maryland Howa	rd	Co.	lumbi							
	it 1	Funeral Director	10e. Street and Number			1	Of. Zip Code			1	0g. Citizen of		
	23a	<u>a</u>	5114 Hesperus Dri					L044		W N/	United States Yes or No- 14. Raca - American Indian.		
	or de		11. Marital Status	12. Was Decedant Eve Armed Forcas?	r in U,S.	13. Was	Decedent of I s, specify Cub	tispanic Orlg an, Mexican,	Puarto	ecify Yes or No- Rican, atc.)		ca - Ameniack, White,	
020	by [1.0]		1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 2 ██No if Yes, Give Year or Dates:		10	Yes 25No	Specify:			Speci	fy: W	Thite
5-0			15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	Decedent	's Usual Occup	ation during most	of work	ina	16b. Kind of 8	3usiness/In	ndustry
21			Elementery/Secondary (0-12)	College (1-4or 5+)		life. DO	f of work done NOT use retire	d)					
	filed with Hygiene. Ither than	Ö		4	Med	dical	Transo	1			Medica		ctice
nd	should be file and Mental Hy merked other matic event.		17. Father's Name (First, Middle, Last)							e (First, Middle, I	Maiden Suma	me)	
Na Na			Herbert J. Wettera	.u				Viole	t Wi	illiams			
lar			19a. tnformant's Name/Relationship (7						al Route Number				
	1 and 2 Health em 27 I]	Norman Jurkscheit					5 Driv	e Co	olumbia,			
Baltimore,	00		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐		20b. Place of cemeter	f Disposition ry, cremeto	on (Name of ony or other ple	ce)		Date	20c. Location	- City or T	own, State
E	permit. Peges Department of Informant: If its any injury or of		4 □ Donation 5 □ Other (Specify		Metro	Crem	atorv		13	3-5-98	Catons	ville	Maryland
alt	Departition Departments imports any injury once.		21. Signature of Funaral Service Licen	500	- /	22. Na	ama and Addre		/				-
0	88558		Xana () 1	SP 11	Theo					Pamily F			
		+	23a. Part1. Enter the disease, or comp shock, or heert failure. List only	Dications that causad the	dgath. Do	not enter th	ne moda of dyi	ng, such as	la l	or raspiratory arr	est,	LITY,	MD 21043 Approximete
-	Physician	1	shock, or heert failure. List only	ne ceuse on each line.	/								Interval Between Onset and Death
	/Medical	1	Immediate Cause (Final	00.1	1-1	- (olo	C		200			5
Ш	Examiner		disease or condition resulting In death)	a. / 12 tas	Hall	-		7 4	m	Elv.			9003
		6		Due	e to (or es e	consequen	ice of):						'
	nsit	Examiner		b								1	
-	death certificate be executed e attending physician end ed for use as the burial-transit	Xa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due	e to (or es e	consequen	ice of):						
68760,	be		Cause. Enter Underlying Cause (Disease or Injury that initiated events	C									
387	phys the	edical	resulting in death) Last	Due	e to (or as a	consequen	ca of):						
	ding pt	Σ		d									
Box	attendii for use	Physician											
o.	the de	ysic	Part II. Other significant conditions of	intributing to death but n	ot resulting in	n the under	rlying cause gi	ven in Pert I.		23b. Did to	obacco use c	ontribute t	to the cause of death?
0	law requires that the de as been signed by the 2 should be detached	7								1 U Y	'88 2 No	3 □ Pro	obably 4 Unknown
IS,	8 C 9	2										0.45 14	Mara automou fin din an
Records,	been should	Сотрінте								24a. Was a perfor	n autopsy med?	81	Vere autopsy findings vallable prior to completion of cause
ec	has by	D D											f death?
	The ate h	0								1□ Y	es 20 No	1	☐ Yes 2☐ No
of Vital	ysicien: The is certificate hi		25. Was case referred to medical					26. Place	of Deat	th (Check only or	ne)		
1	Physicien: this certific	0	examiner? 1 ☐ Yas 2 ☒ No	Hospital: 1 ☐ Inpatiant	2 ER/O	utpatient	3 DOA Ot	her: 4 Nu	rsing Ho	me 5X Resid	ence 6 🗆 O	ther (Spec	rity)
	g Phys er this eral di	-	27. Manner of Deeth	28a. Date of Injury (Month, Day Ye	28b.	Time of Injury	28c. Inju	ry et		28d. Describe h	ow Injury occu	urred	
0	ath. :: After e funer	ario	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		buil)			Yes 2 1	No				
Division	Attending or death.		3 Suicide 6 Could not be determined	200. Placa of Injury		arm, street,	factory, office			28f. Location (S	treet and Nun	nber or Rui	ral Route Number,
Ö	afte Dir	Certification:	4 Homicide	building, etc. (\$	Specify)					City or Tow	11, 31818/		
		edical		yalclan: To the best of m linar: On the basis of exa and manner stated	aminetion an								
	thin the	Σ	29b. Signatura and titla of certifier	and mainler stated			29c. Licen	sa number			29d. Data sign	ed (Month	, Day, Year)
	F 3 F 8		1 1 7				100	1	94				
	24		Willen the	MMD			1-5	.0 /	01	,	March	5, 1	998
	3		30. Name and eddress of person who	wers m	h (Item 23a)	8 SJ	LIT	1e Pa	lys	nt C	Okml	2191	mo
	State Registra		MAR 06 1998	Julia Registrar's	Signature	ň			,				

DHMH 16 Rev 6/95



Baltimore, Maryland 3331 Brehms Lane, Baltimore, Maryland 21213 Approximata Intervel Between Onset end Death 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings evailable prior to completion of cause of deeth? 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 24 hours 1 Certifying Physician: To the bast of my knowledge, death occurred et the time, data and place, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, data end place, and due to the cause(s) end manner steted. 29a. Certifier edical (Check only one) within 2 To the 29b. Signature and Marie ogsifier 29c. License number 29d. Data signed (Month, Day, Year) D46029 MARCH 3 - ATTENDING PHYSICIAN 30. Name and eddrass of person who completed cause of deeth (Item 23e) (Type, Print) ABDUL K- GARNBA MD 12137 ELM STREET PRINCESS ANN, MD 21853 T.L.C. 32. Registras Signiture

Juna Davidson-Randall 31. Data filed (Month, Day, Year) State MAR 06 Registrar **DHMH 16 Rev 6/95**

3. Time of Deeth

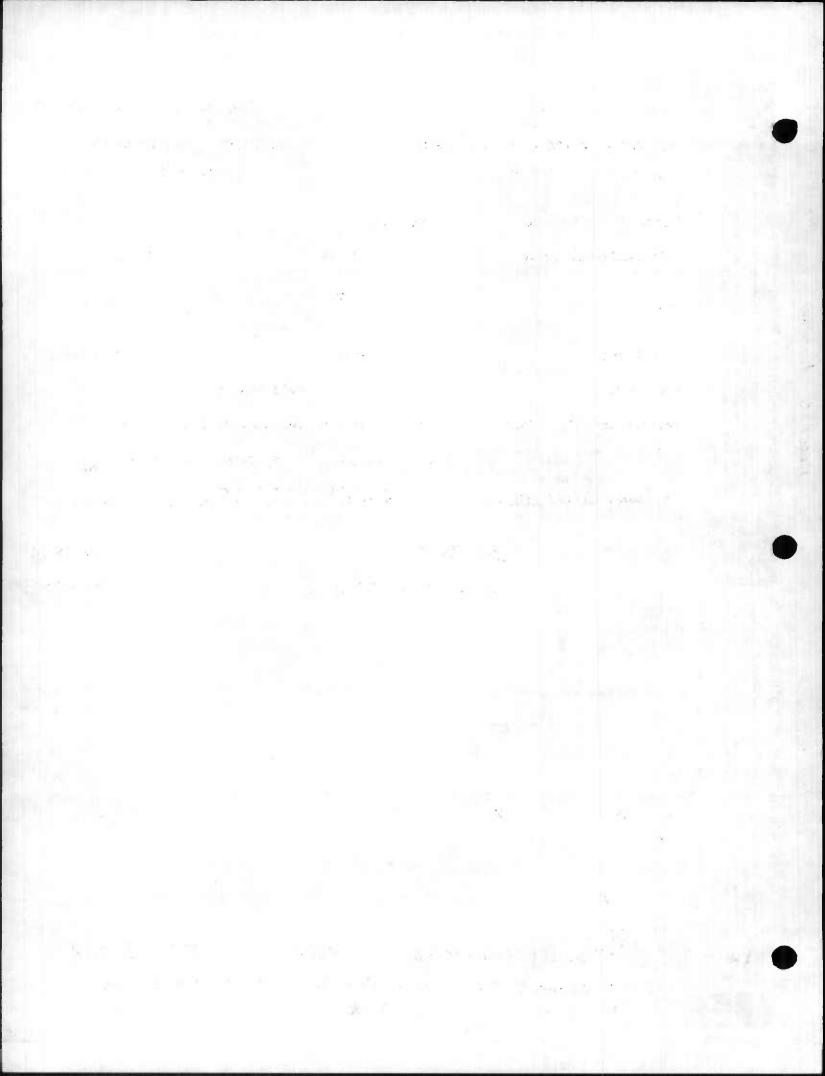
1840

10d. Inside City Limits

1 Yas 27 No

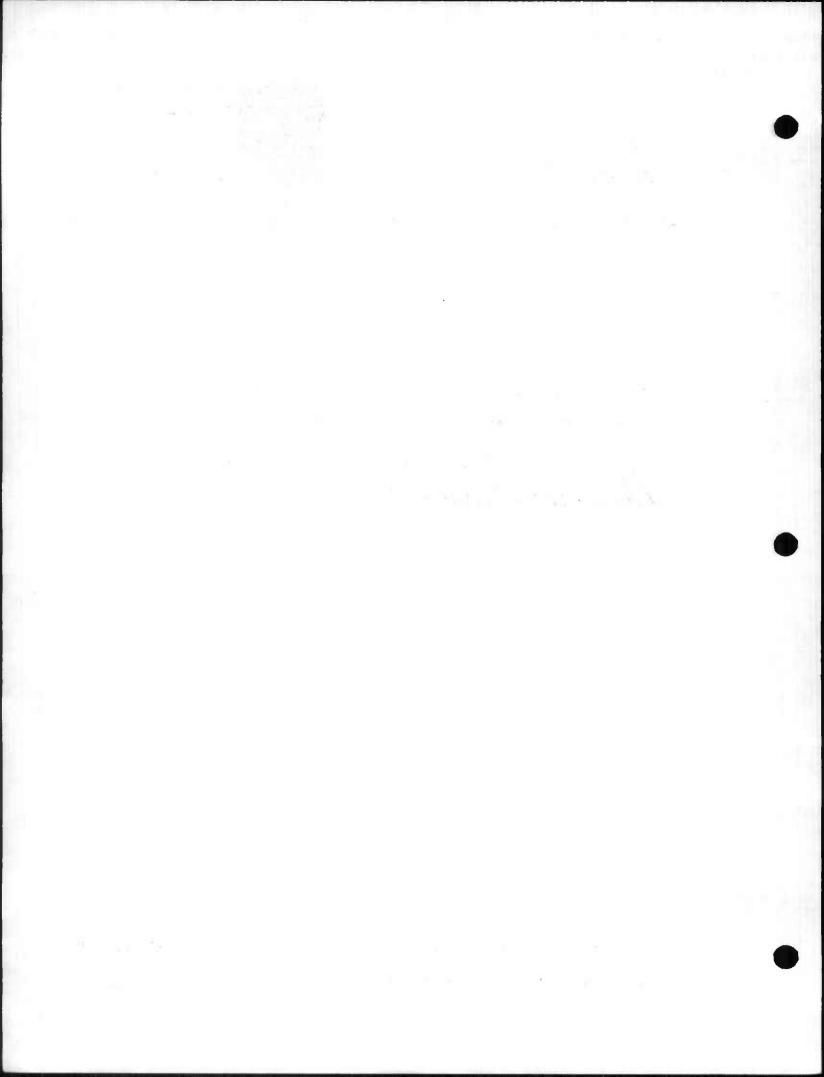
Maryland

White



I	tem	# 1 per Phy G 757		Certifi	cate of	Death	1	Reg. No.		
Physic	:ian	Decedent's Neme (First, Middle, Last	•				2. Dete of De Month	Dey	Yeer	3. Time of Deeth
/Med	ical	LINCOLN KING . 4a. Fecliity Neme (If not Institution, give				4b. City, Town, or L		1998 4c. County		9:33M
Exam	ner	Sunshine Home	street end number)			Baltimor		N/A		
Funera			ex 7. Age (In yrs		Under 1 Yeer	If Under 24 Hrs.			9. Birthple	ece (Stete or Foreign
Directo		212-20-3798	7. Age (In yrs	Yrs. Mo	nths Days	Hours Min.	Apr.8.	1926	Mary	ry)
P .		Usuel Residence of Decedent	10-0	ih. Tour and analis						
72 hours efter deeth with the Manyand natural, or tems 23a or 28a-f show deal Example: must be notified at	2			ity, Town or Locatio	en .				10	od. Inside City Limits N□XYes 2□ No
the N	ecto	10e. Street end Number	Da	ltimore	Of. Zlp Code		1	10g. Citizen of \	Mhat Count	1111
with with	Ö	5419 Daywalt	Avanua		21206	;		U.S.A		ryr
Jeeth Jeeth	Jera	10e. Street end Number 5419 Daywalt 11. Maritel Stetus 1 Never Merried 2 Married 3 Marided 4 Divorced	12. Was Decedent Ever In	U,S. 13. Wes		ispenic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		e - America	an Indien,
ofter of	F	1 ☐ Never Merried 2 ☐ Married	Armed Forcas? 1 XYes 2 ☐ No	If Ye	s, specify Cubi res 2 No		Rican, etc.)		ck, White, a	
raf, c	by	3 Widowed 4 □ Divorcad	1 XYes 2 No If Yes, Give Yeer or Dates: WW I	I. 10	res 2£3 No	Specify:		Specify	v: B1	ack
ammit. Pages i and 2 should be filled whin 72 hours Department of Heelth and Mental Hygiena. Important: If flem 27 is marked other than "natural", any fujury or other traumatic event, the Medical Example.	Completed	15. Decedent's Ed (Specify only highest gre	ucation de completed)	16e. Decedent'	Usuel Occup of work done	etion during most of world)	king	16b. Kind of B	usiness/ind	ustry
d 2 should be filed within the and Mental Hygiena. 7 is marked other than "traumatic event, the Men	du	Elamantary/Secondary (0-12)	College (1-4or 5+)	Labore		d)		Constr	not i	on Work
Hygin Hygin	ပို	17. Fether's Neme (First, Middle, Last)		папоте.		18. Mother's Nerr	a (First, Middle,			OII WOLK
ental ced o	To Be	Lincoln Magaz:	ine .Ir			Grace J				
M Pul	-	19a. Informant's Name/Rejetionship (7		19b. Mailing A	idrass (Streat	end Number or Ru			Stete, Zip	Code)
27 is		Charles E. Jon	nes, II.	1633	Vorth	rick Roa	d Balt	imore,	MD	21218
item r oth		20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐		Plece of Disposition cemetary, cremato	(Neme of y or other plea	00)	Date	20c. Location -	City or Tov	vn, Stete
ant: H		4 □ Donetion 5 □ Other (Specify	Md	Vetera	-		/9/98	Garris	on,	MD
Department of Heelth a important: If item 27 is eny injury or other transcence.		21. Signeture of Puneral Service Licen	1	22. Na M 2 r	me end Addre	ss of Fecility W. Jone	c Ir F	unoral	Hom	o P A
10 = 5 6		Deria a	damas	410	l Edmo	ndson A	venue.	Balto	. MD	21229
		23e. Part1. Entar the diseese, or comp shock, or heert failure. List only	olicetions thet caused the decone cause on each ine.						1	Approximata Intervel Between
hysician			V							Onset end Deeth
/Medical xaminer		Immediate Ceuse (Finel disease or condition resulting In death)	. ARTERIOSC	CLEROTIC	HEAR'	T DISEAS	SE			6 YRS.
	ē			or as a consequent	ce of):					15
ansit	Examiner		HYPERTENS	O LON (or es e consequenc	a of h				<u> </u>	15 YRS.
an an	Exa	Sequentielly list conditions, if eny, leading to Immadiata cause. Enter Underlying Cause (Disease or Injury	CHRONIC F						i I	5 YRS.
hysician and the bunal-transit	dlcai	Ceuse (Diseese or Injury thet initiated events resulting in death) Lest	C	or es e consequenc						J IRB.
iding physician and isa es the bunal-transit	Med	resulting in death) Lest							İ	
1 m	Physician/Me		d						+	
igned by the ette be detached for	/sici	Peri II. Other significant conditions co	ontributing to deeth but not re	sulting in the under	ying cause giv	en in Pert I.	23b. Dld	lobacco use co	ntribute to	the cause of death?
d by		Old Cerebrova	scular Acci	dent wi	th		1 🗆	Yee 2□ No	3 Prob	ably 4⊠ Unknown
signe d be	d by						240 18/00	an autonou	24h We	ra eutopsy findings
been signed by the should be detache	Completed		Left Hemip	aresis			perfo	en eutopsy rmad?	con	ileble prior to
ate hes b	mp							APST.		leath?
		25. Was case referred to medical				00 Diseased David		Yes 2016lo	1	Yes 21 No
this certific	To Be	exeminer?	Hospital:	☐ ER/Outpatient 3	DOA Oth	26. Place of Dea		dence 6 □Oth	er (Snerih)	1
		27. Manner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time of	28c. Injur Wor			now injury occur		/
r death octor: Afte by the fund	atio	1 X Neturel 5 ☐ Pending 2 ☐ Accident Investigation		Injury		Yes 2 □ No				
	ertification:	3 ☐ Suicide 6 ☐ Could not be detarmined	28e. Plece of Injury - At I building, etc. (Space	nome, ferm, street,	actory, office		28f. Location (3	Street end Numb	ber or Rurel	Route Number,
最長	0	,								
Fig.	edlcai	(Check only 2 Medical Exam	valcian: To the bast of my kn iner: On the basis of axemin	owiedge, death occ etion and/or investi	urred et the tir pation, in my o	ne, date end plece, pinion, deeth occur	end due to the red et the time,	ceuse(s) end me dete end plece,	enner as ste	eted. the cause(s)
To the comple	Med	29b. Signeture end title of cartifier	end menner steted.		29c. Licens					
¥ ₽ 8		NA A	2 M	D.	D17			29d. Date signe March		
		7	ri.	L/ 0	ודנו	, 20		ridi CII	٥, -	
		20 Nome and address to the control of the control o	am alabad and a second at the second	- 00-1 /T - D						
		30. Neme end eddrass of person who days Ba Yin Oung,		m 23e) (Type, Print) 22 Bela		. 1	Balto.	, MD	21236	5

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death KELCH Month Yaar MICHAEL 7-46PM ,1198 MARCH 4a. Facility Nama (If not institution, giva street and number) 4b, City, Town, or Location of Death 4c. County of Death ledical 2a EN MORGE TER If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, 5601 - 8 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) Days Hours 10M 20 F 217-54-4980 Yrs. Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 TYSS 2 No AG Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21229 UZA 10 NOSTERU 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarlcan indian, Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 ☑ No Specify: Blac Specify: 3 ☐ Widowad 4 ☐ Divorced 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) achine OPPER 11+1 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) TRENE KRNEST 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) BROTLER Road 9822 Kg 51133 Kelch-Southall TURONE K 20a. Method of Disposition andallstown 20b. Place of Disposition (Nama of comatary, crematory or other place) Data 20c. Location - City or Town, Stata 1 ⊠ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata MEMORIAL TARK 4 ☐ Donation 5 ☐ Othar (Specify) ANDAISOWN 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Facility Home West, INC mc.n lare 4300 Wabash 23a. Part. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lefture. List only one cause on each line. Approximata Intarvai Batween Onsat and Death Immediata Causa (Final andiomyopathy disaasa or condition rasulting in death) Dua to (or as a consequanca of) Phedmini Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or injury that initiated events rasulting in daath) Last Dua to (or as a consequence of) Failure hirator Dua to (or as a consequanca of) Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 ™Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 25. Was casa raferred to medical axaminar? 26. Piaca of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturai 5 Pending 2 Accident

physician end s the buriel-transit P.O. Box 68760, signed by the attending d be detached for use as Division of Vital Records, After this deeth. To the Hospital or Attendit within 24 hours after deeth.

To the Funeral Director: A completely filled in by the fu

Physician/Medical

by

Completed

Certification:

Medical

Physician /Medical

Examiner

Physician

/Medical

Examiner

Director

Funeral

ģ

Director

permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Manyland Department of Health and Mental Hygiene.
Important: If them 27 is a marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Amolical Examiner must be notified at

Baltimore, Maryland 21215-0020

1 Yas 2 No 27. Manner of Death

invastigation 3 ☐ Suicide 6 Could not be determined

1 Yes 2 1No 28e. Piace of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

Location (Street and Number or Rural Routa Number, City or Town, Stata)

4 Homicida

29a. Certifiar

112 Certifying Physician: To the best of my knowledga, daath occurred at tha time, data and place, and dua to tha causa(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to the causa(s) and mannar stated.

HT

29b. Signature and titla of certifiar

31. Data filed (Month, Day, Yaar)

29c. Licensa number

29d. Data signed (Month, Day, Year)

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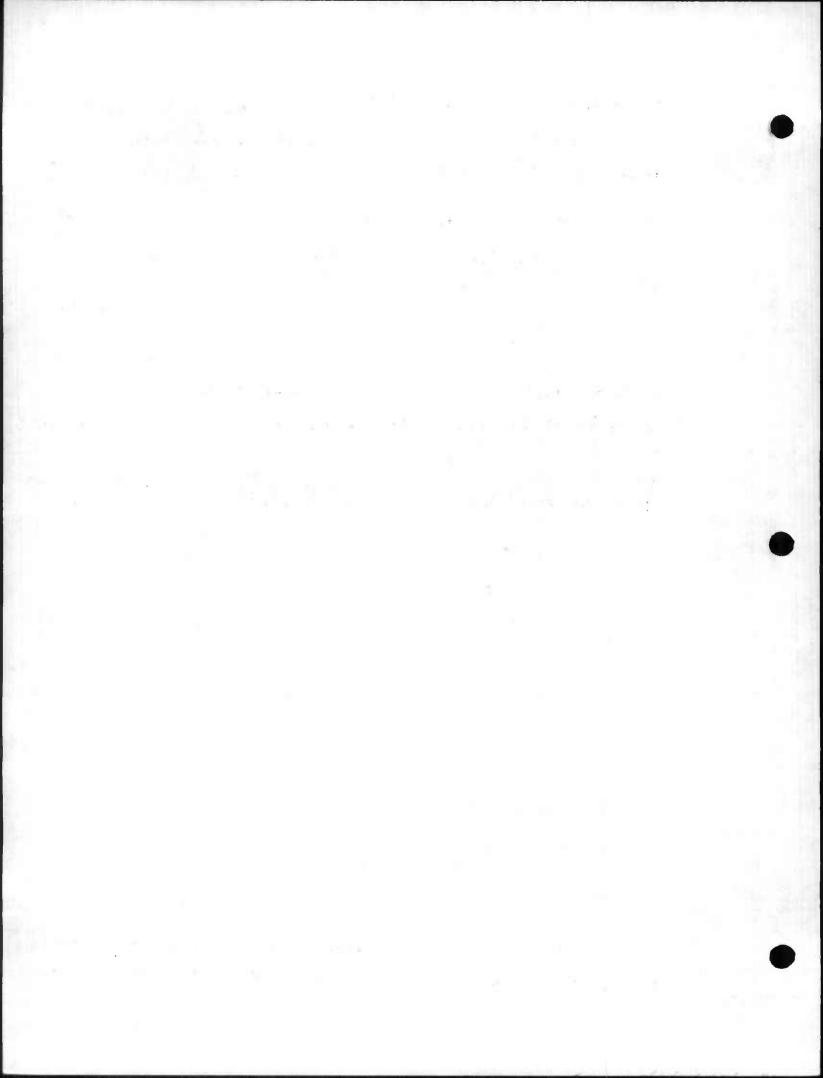
30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

LIBERTY R. M-SHAH LMC 2000

Balhmore MD 21415

State Registrar

32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 26 per MD G-757 3/6/98 dh 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** February 27, Donald S. Letke. Sr. 1998 2:30 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore 3407 Roselawn Avenue 8. Dete of Birth (Month, Dey, Year) If Under 24 Hrs. 5. Social Security Number 6. Sex If Under 1 Yeer 9. Birthplace (State or Foreign 7. Age (In vrs. lest birthdev) **Funeral** Months Hours 67 Yrs. 212-26-9237 May 22, 1930 Maryland Director Usuel Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits North Carolina 1 ☐ Yes 2 X No McDowell Director Nebo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Rt. 1, Box 525 U.S.A. 28761 Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indien. 11. Meritel Stetus Bleck, White, etc. 1 Never Merried Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Transportation Management 12th grade 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Helen Novack Letke Herman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Rt.1, Box 525, Nebo, North Carolina 28761 Ada May Letke (wife) 20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 20b. Place of Disposition (Name of cametery, cremetory or other place) Dete 20c. Location - City or Town, Stete Holly Hill Mem'l Gardens 3/2/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Schimunek Funeral Home, Inc. 21. Signeture of Funeral Service License who 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel ESOPHAGEAL CANCER 9 MONTHS diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medicai Due to (or es e consequence of): 23b. Did tobecco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 Ves 2 No 1 □ Yes 2 □ No 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) eXXIOther (Specify) son sence Other: 4 Nursing Home & Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

The law requires that the death certificate be executed physician and s the buriel-transit Division of Vital Records, P.O. Box 68760, signed by the a d be detached f certificate has birector, page 2 s Attending Physician: this funeral After s eftar decasal Director: Aftr 124 hours eftar Ne Funeral Directle bletely filled in b ò

the Marylend

"natural", or frams 23a or 28a-f show

d 2 should be filed within 72 hours after death with it hand Mentel Hyglene.
I la marked other than "natural", or flems 23a or : traumatic avent, the Medical Examine Immatica.

Pages 1 and 2 should be 1 nent of Health end Mentel

DAALD

of Health er.

Certification: To

27. Mennes of Deeth

1 Neturel

29a. Certifier

(Check only one)

5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28e. Date of tnjury (Month, Dey Year)

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier

MEDICAL ON COLOGY 29c. License number FELLOW

DO0 50753

FEBRUARY 27, 1998

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

JOHNS HOPKINS ONCOLOGY CENTER STREET, BALTIMORE, ILJAS ELISABETH

Registrar

Medical

31. Dete filed (Month, Day, Year)

MAR 06

32. Registrer's Signeture Fulia Davidson

DHMH 16 Rav 6/95

Hospital

To the Hosp within 24 ho To the Fune

29d. Date signed (Month, Dey, Yeer)

600 NORTH WOLFE

The late of the late

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Lutz 8:45 AM -ouis March 1998 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Good Samaritan Hospital Baltimore Baltimore City 6. Sex 1 M 2 F If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Feb. 20, 1916 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Deys Hours 218-07-3308 82 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7012 Belclare Road 21222 U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? 1 (A Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Stetus 1 Never Merried 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Race Track 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augustus Lutz I. Effice Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Linda Kelly (daughter) 7012 Belclare Road, Baltimore, MD 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 X Burlel 2 □ Cremation 3 □ Removel from Stete Loudon Park Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 3/9/98 Baltimore, Maryland 21. Signature of Funerel Servica Licansee 22. Name end Address of Fecility Schimunek Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) a. Myocardial Infarction Due to (or es a consequence of): minutes Atheroscleratic CardiovascularDisease Diabetes Mellitus and Hypertension Zoyear Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Lacurar Cerebrovascular Accidents 1 Yes 2 No 3 Probably 4 Unknown Urinary Tract Infection

Physician /Medical Examiner

ettending physician end for use as the buriel-transit

signed by the et d be deteched for

certificate

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica

The lew requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a Stete

Directo

Funeral

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Completed

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permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or itema 23s or 28s-f show with injury or other traumatic event, the Medical Evantment is at the inditing an once.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Lest

24a. Was an autopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of death?

2 0 No

1 ∏Yes 2 ∏ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

1 Inpatient 2 ER/Outpatient 3 DOA 5 Pending investigation

28a. Date of Injury (Month, Day Year)

Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

1 Naturel

2 Accident

3 Sulcide

4 Homicide

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year) March 4, 1998

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

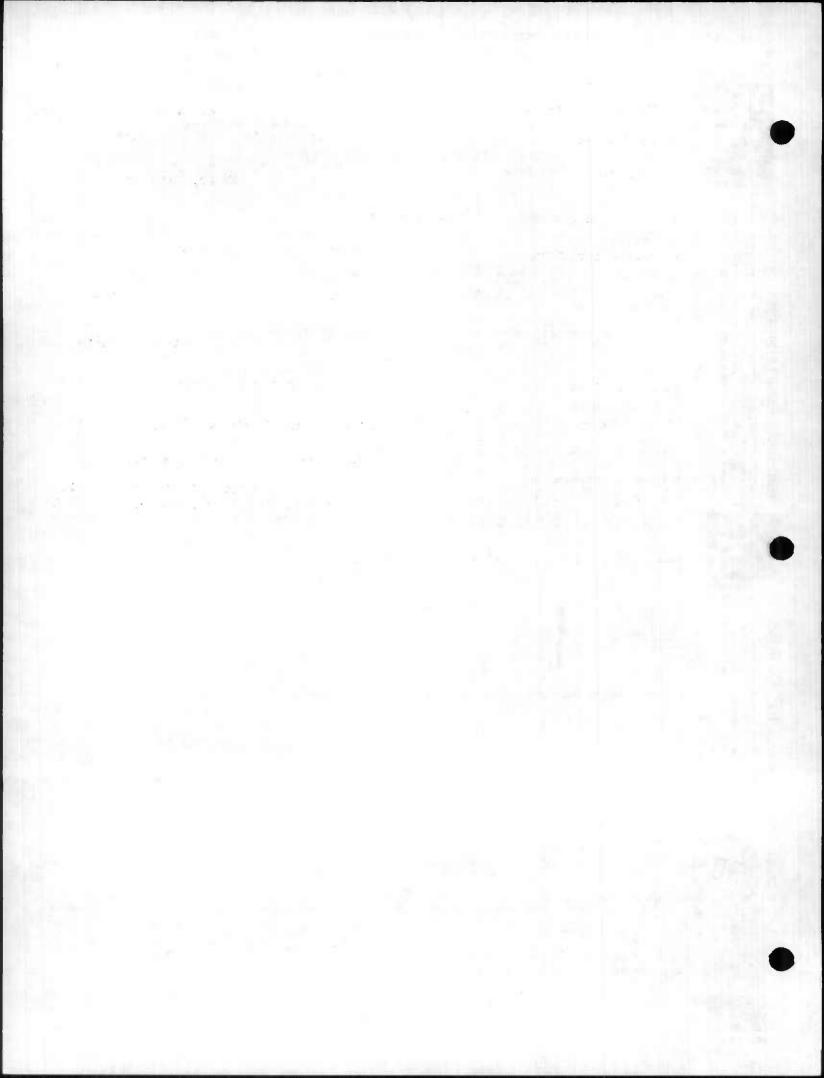
Thomas 5. Witson MD 5601 Loch Raven Blud Baltimore 21239 32 Register Signatur door 31. Date filed (Month PARea) 6

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Alice 28 1998 -LD /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Inns of Evergreen N/H NA If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 M d 8. Date of Birth (Month, Dev. Yeer) **Funeral** 1□M 2XF Deys 92 Yrs Director 093-12-8180 6/29/05 Baltimore Usual Residence of Decadent should be filed within 72 hours after death with the Maryland nd Mentai Hygiene. marked other than "naturef", or Items 23s or 28s-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Ves 2 □ No Baltimore Md 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21213 Lafayette Ave. 1920 E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: Black 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA Domestic 9th Grade various trades 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Pages 1 end 2 should be nent of Heelth end Mental 2 Chavis Ora Garfield J. Dockery permit. Pages 1 end 2 sh Department of Heelth end Important: If itam 27 ia m any injury or other traum once. 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1920 E. Lafayette Ave./Balto, Md Jones Hazel Baltimore, 20b. Placa of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 03-05-98 Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility 21202 Md Baltimore, March F/H 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as e consequenca of): Box 68760, ettending physician Physician/Medical Due to (or es e consequenca of): Division of Vital Records, P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Was en autopsy performed? 1 ☐ Yes 2 No certificate 1 Yes 2 No or Attending Physician: 25. Was case rete 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 1 Inpatient 2 ER/Outpatlent 3 DOA this 27. Manner of Deeth 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury deeth. 1 Yes 2 🗆 No 2 Accident thei within 24 hours efter deet To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier one) 29b. Signature and # 29c. License number 29d. Date signed (Month, Dey, Year)

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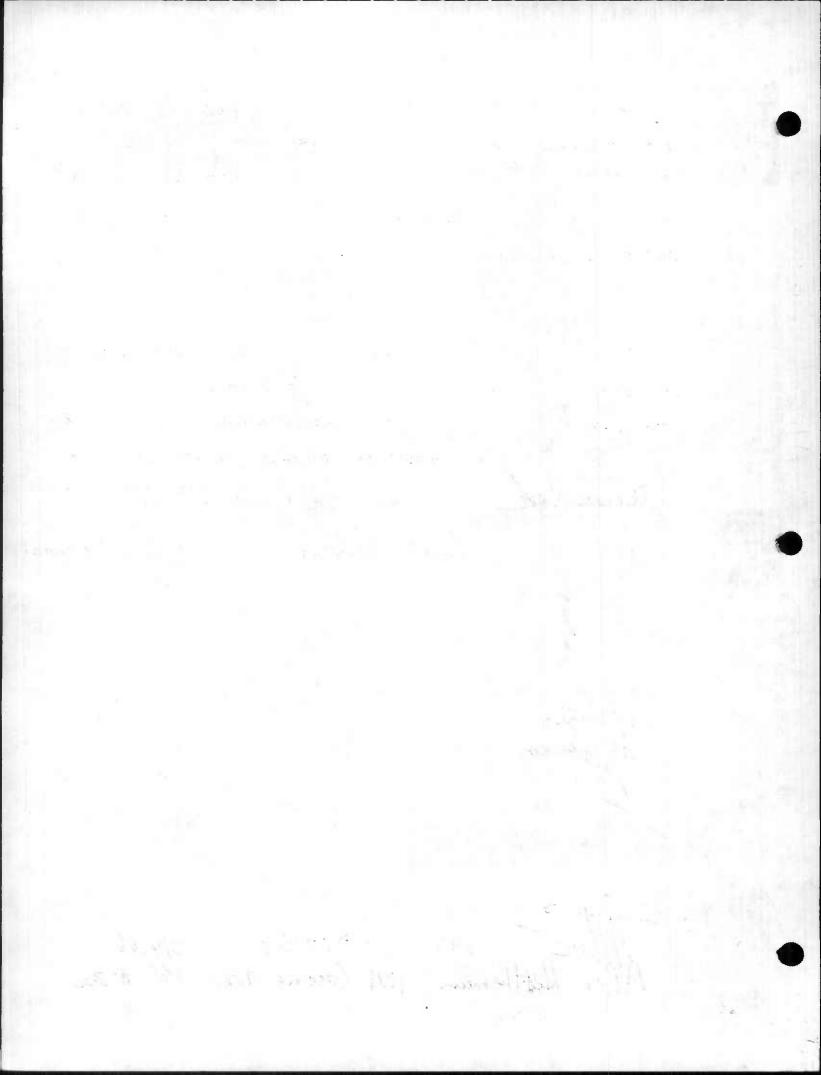
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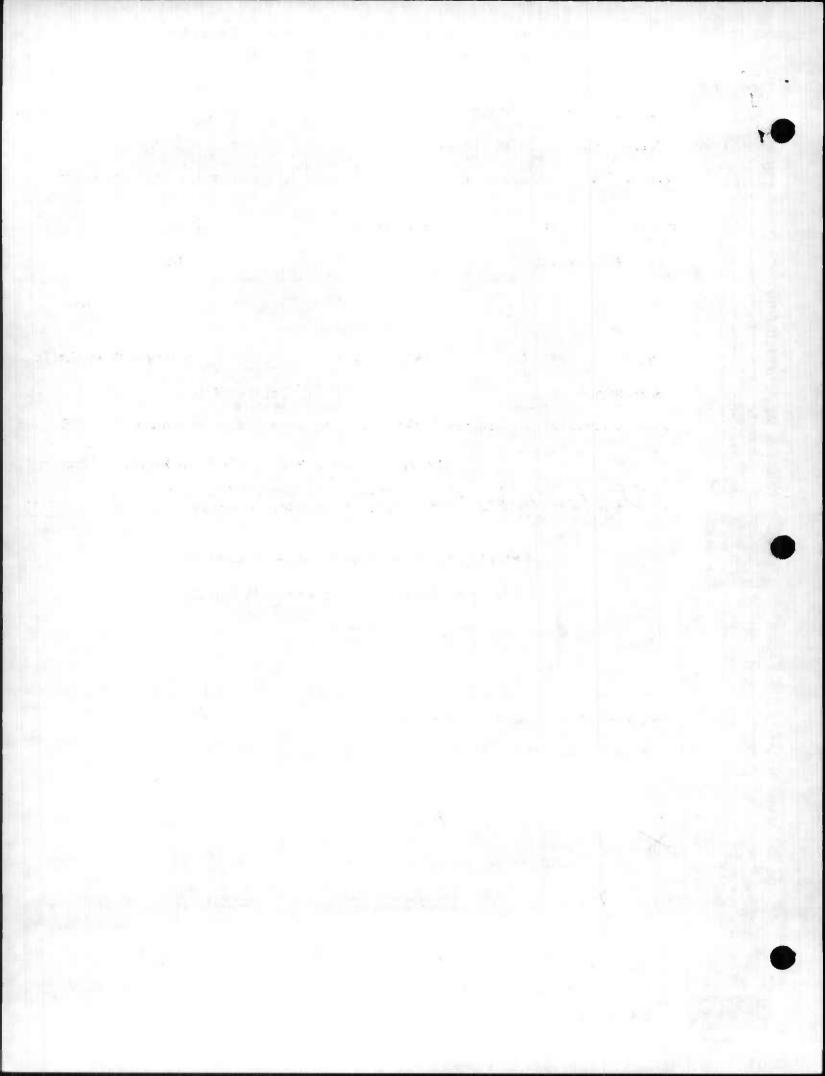
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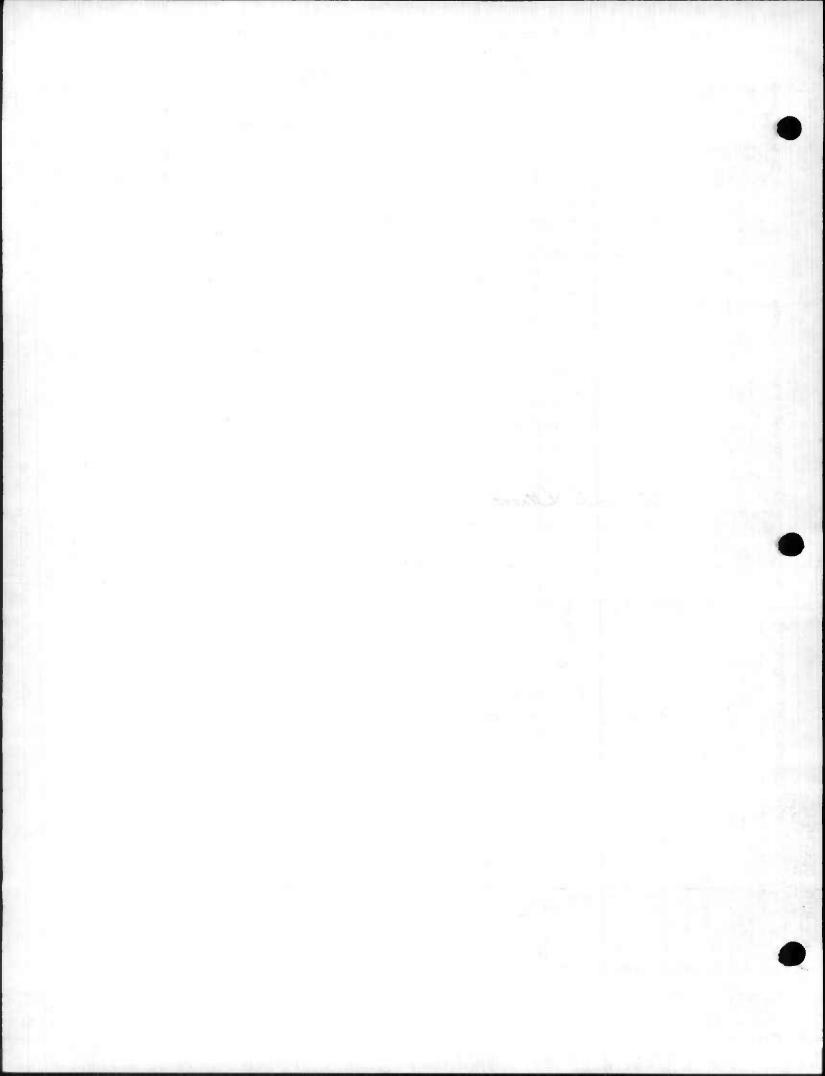
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q Q

Physicia		1. Decedent's Nama (First	Middle, Las	st)				of Dea		2. Data of Da			3. Tima of De	
/Medic		RUTH		LEITNER						Month 02	Day 21	Year	2:30	
Examin		4a. Facility Nama (If not In:	stitution, give	a street and numbe	r)			4b. City	, Town, or L	ocation of Deat	h 4c. County	of Death		
		Suburban Hos	pital					Be	thesda	ı	Mont	gome	v	
Funeral		5. Social Security Number	6. S	ex 7 □M 25xF	Age (In yrs	last birthday)	If Under 1 Y Months Da	ear If Ur	dar 24 Hrs.	8. Data of Bi (Month, Di	th ry, Year)	9. Birthp	placa (Stata or Fi	
Director		102-09-3509 Usual Residence of Deced	_	CIN SOLL	8.	5 Yrs.					, 1912		oklyn,	
ž ==			County		10c. C	ity, Town or Lo	ocation					1	0d. Insida City L	
r 28a-f show Inciting at	ğ	Maryland Mo	ntgom	erv		Rockv i l	1e						1 ☑ Yas 2	
7.28a	9	10e. Street and Number	11-6011				10f. Zip Cor	ja			10g. Citizan of	What Cour	ntry?	
rns 23a or 28a-f show r must be nothing at	0	257 Congress	ional	Lane, A	ot. 6	80		20852			U.S.	Α.		
or Items miner m	by Funeral Director	11. Marital Status 1 Naver Married 25 3 Widowad 4 Dh		12. Was Decede Armed Forca 1 ☐ Yas 2 ☐ If Yas, Giva Year or Data:	No		Was Dacedant If Yes, specify (1 ☐ Yas 2 🔀			en, Puarto Ricen, atc.) B			Race - Americen Indian, Black, Whita, atc.	
natural',	B	15. Da	cedant's Ed	lucation		16a. Dece	dant's Usual O	cupation		ce .	16b. Kind of B	usinass/in	dustry	
pene. r than "natural", the Medical Exe	Completed	(Specify only Elementary/Secondary (da complated) College (1-4c	r 5+)	(Giva	DO NOT usa ra	ine dunng i tired)	g most of working					
n end Mental Hygiene. Is merked other then ' raumatic event, tra Me	Con	10th Grade				HADAS	SSAH -	Regio	nal Pr	esiden	Volu	intee	c	
d oth	Be	17. Fathar's Name (First, M									, Maidan Suman	na)		
Men Parke	70	Isadore Fiel							elia F					
ls m traun		19a. Informant's Name/Ra				19b. Malling Address (Straat and Number of								
it of Health end Mental Hyg If Nem 27 is merked other or other traumatic event,		Sherri Tanze	er, Da	ughter	20h				Lane #31, Colum		20c. Location			
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Important in once.						S	2. Nama and Ac TEIN HE	BREW	MEMOR]	AL FUN	ERAL HOM	Æ, I	, INC.	
	-	Oonald			my	2	32 CARR	OLL S	TREET,	NW, W	ASHINGTO	ON, D		
tete		23a. Part1. Entar the disas shock, or heart failure	. List only	ona causa on aach	ilne.	III. DO NOT ANI	ai tha moda oi	dying, suci	as carolac	or raspiratory a	masi,		Approximata Interval Batwee Onsat and Dea	
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g physician end es the burial-transit	Examiner	Sequentially list conditions		b. —	Dua to (or as a conseq	juence of):	00					/ Unoy	
ian e	<u>a</u>	Sequentially list conditions if any, laading to Immadiat causa. Entar Underlying Cause (Disaasa or injury										i		
he b	edical	that initiated availts		С.	Dua to (d	or as a consaq	uenee oft.							
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ate hes been signed by the attendin page 2 should be deteched for use	by Physician/M	Part II. Other stgniflcant co	ondittona co	ontributing to death				givan in P	art I.	1 □	Yes 2 □ No an autopsy ormad?	3 Prol	bably 4 Unlara autopsy findiallable prior to	
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his certificate hes been signed by the attendin al director, page 2 should be deteched for use	To Be Completed by Physician/M	25. Was cesa referred to maxaminar? 1 Yas 2 No 27. Manner of Death	adicel Panding	Hospital: 1 Inpa	ely had	Tion	nderlying causa	26. P Other: 4 D njury at	iaca of Deat	1 □ 24a. Was parfe 1 □ h (Check only oma 5 □ Rasi	Yes 2 No an autopsymad? Yas 2 No ona)	24b. Windows of 1 [ara autopsy findi allable prior to mplation of caus death?	
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DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 8 07 14 | Certificate of Death Reg. No.

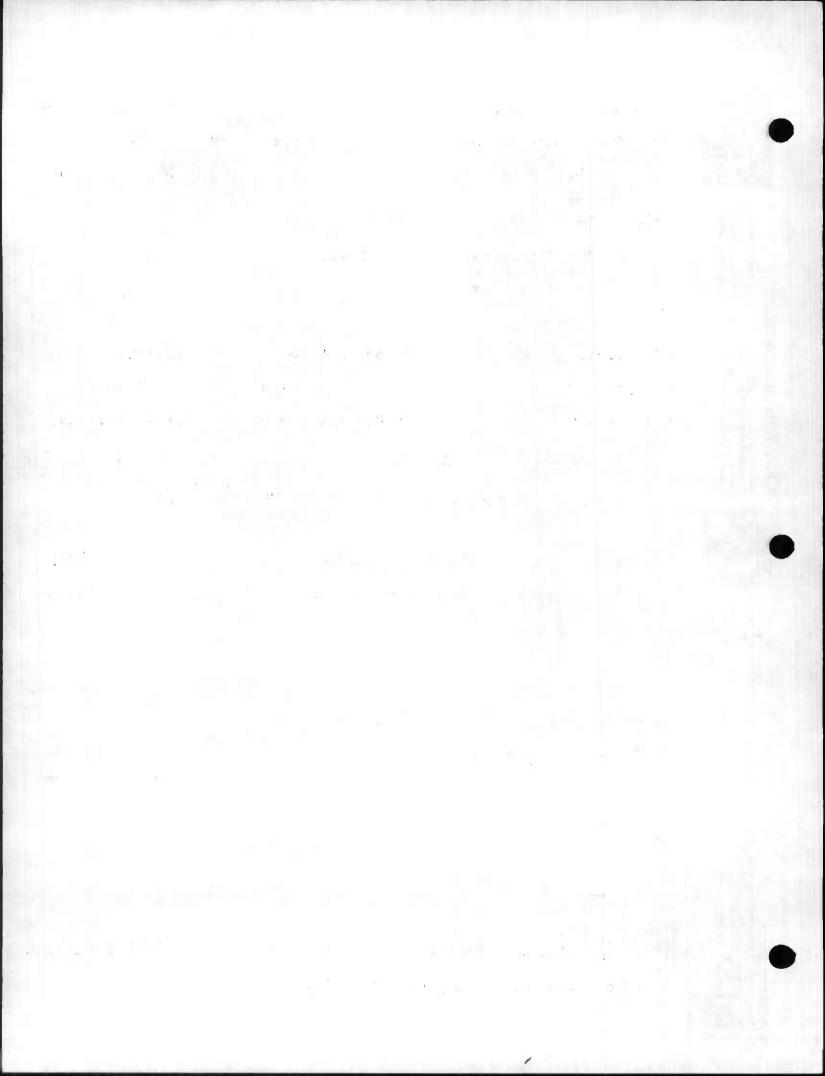
				Ce	rtificate	e of	Death		R	eg. No.	0 1	1 14 1
Physician /Medical	1. Decedent's Name (First, M Joseph D.	Morton							2. Dete of Deel	20	1998	3. Time of Death 5:20AM
Examiner	4e Facility Neme (If not institute 103 Driftwood		m <i>ber)</i>				Jo	ppa	ocation of Death	Н	nty of Death	đ
Funeral Director	5. Social Sacurity Number 218–38–2416 Usual Residence of Deceden	6. Sex 120 M 2□ F	7. Age (in yrs. i	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Data of Birth	Ť941		plece (Stete or Foreign ntry Sylvania
thed at	10a. Stata 10b. Cou			, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2 No
r items 23a or 28a-fs observant be notfled Funeral Director	10e. Street and Number 500 South Ma	rlyn Avenue			10f. Zip 21	Code 221			1	0g. Citizen o	U.S.A	
0 9	3 ☐ Widowed 4 ☐ Divor	Armed For Aarried 1 ☐ Yes If Yes, Gir	2 No		Was Deced If Yes, spec				ecity Yas or No- Rican, etc.)		lace - Amari llack, White, cify: W	
Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exa page. To Be Completed by	15. Dece (Specify only his Elementery/Secondery (0-1	dent's Education phast greda completed) College (1-4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us Assemb	k done a retire	during mos	t of work	ing	16b. Kind of		acture
Mental Hygie arked other t atic event, it To Be Co	17. Father's Neme (First, Mid				Bocie	,101	18. Mothe		e (First, Middle, I	Maiden Sum	eme)	accure
27 is mari	19e. Informent's Neme/Relett Joann Hillman	onship (Type, Print) (SISTER)	(STER) 103 Driftwoo									
nt: If Item ry or othe	20a. Method of Disposition 1 ♣ Burlal 2 □ Cremeti 4 □ Donation 5 □ Othe		State C6	laca of Dispo emetery, cre air Me	metory or o	thar pla	nca) ns 2	2/23/		20c. Locatio Belai	,	own, Stete
Departm Importa any Inju	21. Signature of Funerel Sen	Ca Licensee							Home P.		Md.	21221
nding physician and See as the bunel-transit was the bunel-transit	Immediate Ceuse (Finel disaase or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying	ist only one couse on a Meta a	Due to (o	r es e conse	quence of):	ci	noma					onset end Deeth Months
0.0	resulting in death) Lest	d	Due to (or	as a consec	quenca of):							
d by the letacher		ditions contributing to d	eath but not rasu	ulting in the u	inderlying c	ause gi	ven in Pert	1.				to the cause of death?
ate hes been signed page 2 should be det									24e. Wes e perfor	en eutopsy med?	8'	Vere eutopsy findings veilable prior to ompletion of cause of deeth?
s certificate hes director, page 2	25 Was case referred to mai	lical					26. Plec	e of Deet	1 ☐ Y			Yes 2 No
After this funeral di	1 ☐ Yes 2 No	28e. Dete (Mon estigation	of Injury oft, Dey Year)	ER/Outpatie 28b. Time o Injury		8c. Inju			ome 5 Residence 128d. Describe h	enca 6 10 ow Injury oc	Other (Spec curred	houser'
within 24 hours effer death. To the Funeral Director: Affert completely filled in by the funeral Medical Certification;	3 Sulcide 6 Co	uld not be ermined 28e. Place build	a of Injury - At he ing, etc. (Specify	ome, ferm, st	reet, factory	, office			28f. Location (S City or Tow		imber or Rui	ral Route Number,
within 24 hours To the Funeral completely filled					vestigetion,	In my	opinion, dee		red et the time, d	lete end plac	ca, and due	to the cause(s)
To the com	29b. Signature and title of cer	my	2	92-1 T	D		854		2	9d. Dete sig	ned (Month 15 48	
		seberg 1	M.D.	301	st.		ul P	lace	Balt	imore	e, Md	. 21202
State Registrar	31. Dete filed (Month, Dey, You MAR	9ar) 32. F	Registrar's Sign	udson-1	fandall							

DHMH 16 Ray 6/95

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State of Maryland / Department of Health and Mental Hygien € 0711

	Decedent's Name (First, Middle, Last	ot)		Certificat	e UI	Dealli	2. Dete of Dec		W-	3. Time of Death	
Physician (Madisal	Elaine	McGuire					Month Match	Day (S PP	3:13 pm	
/Medical Examiner	4e Facility Name (If not institution, give					4b. City, Town, or Lo			7.7		ĺ
	THE JOHNS HOPKIN	S HOSPITA	L			BALTIMORE	CITY	N/			
uneral rector	5. Social Security Number 6. Social Security Number 212-30-3714 Usual Residence of Decedent	D	(In yrs. lest bi	rthday) If Unde Yrs. Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De) 12-18	h y, Yeer) 8-32	9. Birthpi Count	ece (Stete or Foreign lry) Md.	
nd an	10a. State 10b. County		10c. City, Tow	n or Location					10	Od. Inside City Limits	7
ctor	Md. NA		Balt:	imore						1 Yes 2 No	į
Sirecto	10e. Street and Number			10f. Zip	p Code			10g. Citizen of V	Vhet Count	try?	
la la	2624 E. Federa				213			USA			
by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes ※ ※ ※ N If Yes, Give Year or Dates:		13. Was Dece If Yes, spe		Hispenic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify	a - America k, White, e	etc.	
eted	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	16a	Decedent's Usu (Give kind of wo	ork done	during most of work	ring	16b. Kind of Bu	siness/Ind	lustry	
Completed	Elementery/Secondery (0-12)	College (1-4or 5-	+)	life. DO NOT u	se retire	od)		He and	3		
S	12th Grade 17. Father's Name (First, Middle, Last)	NA		Nurses'	SA	18. Mother's Name	e (First, Middle	Hospit Melden Sumem			
o Be	George June				Susie	- (ebst	er		
2	19a. Informent's Name/Relationship (7	Type, Print)	198	o. Meiling Addres	s (Stree	t end Number or Run	al Route Numbe				
	Rhea Brayboy					Avenue				21212	
	20a. Method of Disposition		20b. Placa o	of Disposition (Na	me of other ple	eca)	Date	20c. Location -	City or To	wn, State	
- Suce	1 Buriai 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify					Cem.03+0	06-98	Rand	dalla	stown, Md	
DUCE.	21. Signature of Funerel Servica Lican	Halla	nd	WM.C.	Ma	rch FH	1101 E	re, Mai	ryla	nd 21202	
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one ceuse on each lin	the death. Do	not enter the mod	de of dy	ing, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
ian cal ner	Immediate Ceuse (Final disease or condition resulting in deeth)		Ulmanar	consequence of)					1	4 days	
ner ne				cnovs Th		0.131			l l	6	
Examiner	Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	b		consequence of)		30117			1	o worth	
or use es me bu	that initiated events resulting in deeth) Last	d	Due to (or es e	consequenca of):	:						
icia	Pert II. Other algnificant conditions of	ontributing to death bu	t not resulting i	n the underlying	cause o	iven in Part I.	23b. Dld 1	tobacco use co	ntribute to	the cause of death?	-
by Phys	O Chronic Obstr									bebly 4 Unknown	
Completed by Physician/N	@ Almonary A	ypertension						en autopsy rmed?	ava cor	ere eutopsy findings allable prior to mpletion of cause death?	
Comp							101	Yes 2 No	10	Yes 2 No	
Be	25. Was case referred to medical exeminer?	110-1				26. Plece of Deal	th (Check only o	one)			
2	1 ☐ Yes 2 ☑ No	Hospital:			UA			denca 6 Oth		y)	
tion	27. Manner of Deeth 1 ☑ Naturat 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) 28b.	Time of Injury M	28c. Inju Wa 1 [iry at ork?] Yes 2 □ No	ZOO. DESCRIDE I	how injury occur	190		
edical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pleca of Injubulding, etc	ry - At home, fa . (Specify)	arm, street, factor	ry, offica		28f. Location (: City or Tox	Street end Numt vn, Stete)	er or Rure	l Route Number,	
Medical Certificat		ysician: To the best o liner: On the basis of and menner ste	examination ar								
M	29b. Signature and title of cartifier			29	c. Licen	se number		29d. Date signe			
	I dig Su		ildent		RT	5-000		3/2/43	S CN	Morch 2, 1498/	
0	30. Name end address of person who a	alon To	WET II	a John	N LA	opkine Ho	pital				
State	31. Date filed (Month, Dey, Year)	QQQ 32. Registra	is Signature	on Aandel	2	1					



Months

10f. Zip Code

21223

7. Age (In yrs. last birthdey)

Yrs.

10c. City, Town or Location

Baltimore

42

PLAUGHL!

Deys

If Under 1 Year | If Under 24 Hrs.

Hours

2. Date of Deeth

8. Date of Birth (Month, Day, Year)

11-22-55

Month

4b. City, Town, or Location of Death

Baltimore

Min

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

YYes 2□No

MD.

10g. Citizen of What Country?

USA

0:00 PM

238 Hems ; 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decadent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify by Specify: Black 3 □ Widowed ¥ ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health end Mentel tygliens Important: If Item 27 is marked other the any injury or other traumatic event, Images. Grave Digger Western Star Cem 9th Grade NA 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be John B. McLaughlin, Sr. Annie E. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 2426 Edmondson Avenue Baltimore, Maryland McLaughlin 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from Stete 4 Donation 5 Other (Specify) Md. Nat'l Cem. 03-07-98 Laurel, Md. 22. Name and Address of Facility 21. Signature of Funeral Service License Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** REN AL /Medical FAILURE Immediate Cause (Final ACUTE disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner MULTIPLE MUNTHS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Lest Due to (or as a consequence of): 68760. Due to (or es a consequenca of) Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? PNEUMONIA 2 XNo 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to Completed 24e. Wes an autopsy performed? completion of cause of deeth? paga 2 s has 2 N No 1 ☐ Yes 2 No certificate 1 ☐ Yes Vital Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Nnpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 25 No Certification: To o this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending PI
 24 hours efter deeth.
 Funeral Director: After the telephy filled in by the funeral Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 D Homicide To the Hospital within 24 hours e To the Funeral D completaly filled edical Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigetion, in my opinion, deeth occurred at the time, date and plece, end due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Julee 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURJIT JULKA M.D., 821 N EUTANST. BALTIMORE MD 21097 JULKA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 06 Registrar DHMH 16 Bay 6/95

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

220-64-8386

Usual Residence of Decedent

10e State

Md

10e. Street and Number

Physician

/Medical

Examiner

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28a-f show

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Director

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4e. Fecility Name (If not institution, give street and number)

10h County

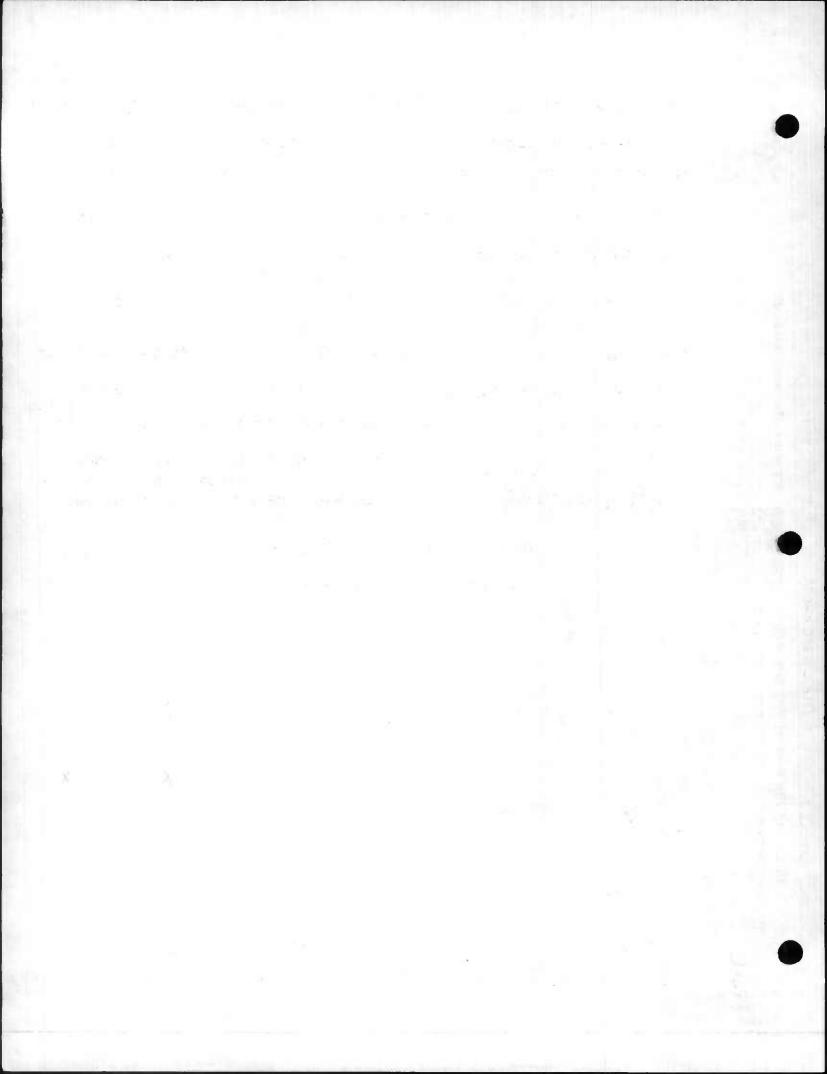
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2426 Edmondson Avenue

BonSecour Hospital

6. Sex

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month Day **Physician** MARCH 9:20 A.M. 4 1998 RAYMOND RICHARD MIGLIARINI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street end number) Examiner BALTIMORE CITY N/A HAMILTON CENTER GENESIS CARE If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplaca (Stata or Foreign Country) **Funeral** 1 M 2□ F Months Days Hours Min Yrs. 86 Director 11/5/11 OHIO 281-05-9238
Usuat Residence of Decedent with the Maryland r 28a-f ehow 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Directo BALTTMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? in than "naturel", or items 23s or Funeral 21234 2304 COVERED BRIDGE GARTH USA 72 hours after death 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced WHITE Completed permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiane. Important: If Itam 27 ie marked other than any Influry or other traument. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8th GRADE YODER HAMMER OPERATOR MARTIN MARIETTA 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middla, Last) MARY BUCCELLI VALENTINO MIGLIARINI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DAUGHTER 2304 COVERED BRIDGE GARTH BALTIMORE, MD 21234 JOAN PIKENS 20b. Placa of Disposition (Neme of cematery, crametory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 € Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH CEMETERY 3/7/98 PARKVILLE, MD 22. Name and Address of Facility

JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 238 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of): Examiner 56 VY Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in deeth) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical Due to (or as a consequence of): signed by tha a 23b. Did tobacco uas contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given In Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Wara autopsy findings available prior to completion of cause of death? should I 24a. Was an autopsy performed? Completed certificate has b mys then is 2 No 1 Yes 20 No Division of Vital Attending Physician: 25. Was case referred to madical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residenca 8 ☐ Other (Specify) 2 1 Yes 2 1 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) funaral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Aftar 5 Pending Investigation 1 GNatural s after des. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours after Funeral Directately filled in b 6 29a. Certifier 1🗹 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the cause(s) and manner as steted. edical complataly 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29d. Data signad (Month, Day, Year) 30. Name and address of person who completed cause of deeth (flem 23e) (Type, Print)

9618 Belcur Ball Balline HOWARD H. BOND 21236 Ma 31. Date fited (Month, Dey, Yeer) 32. Registrar's Signeture State

Registrar

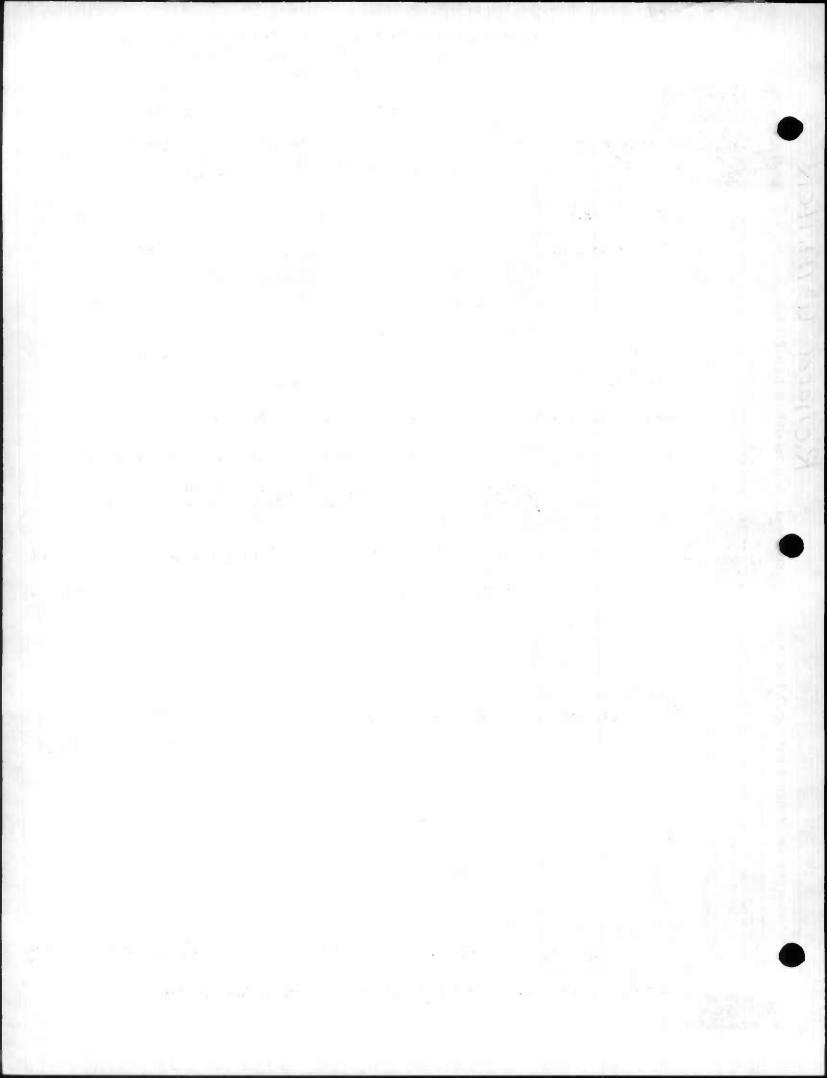
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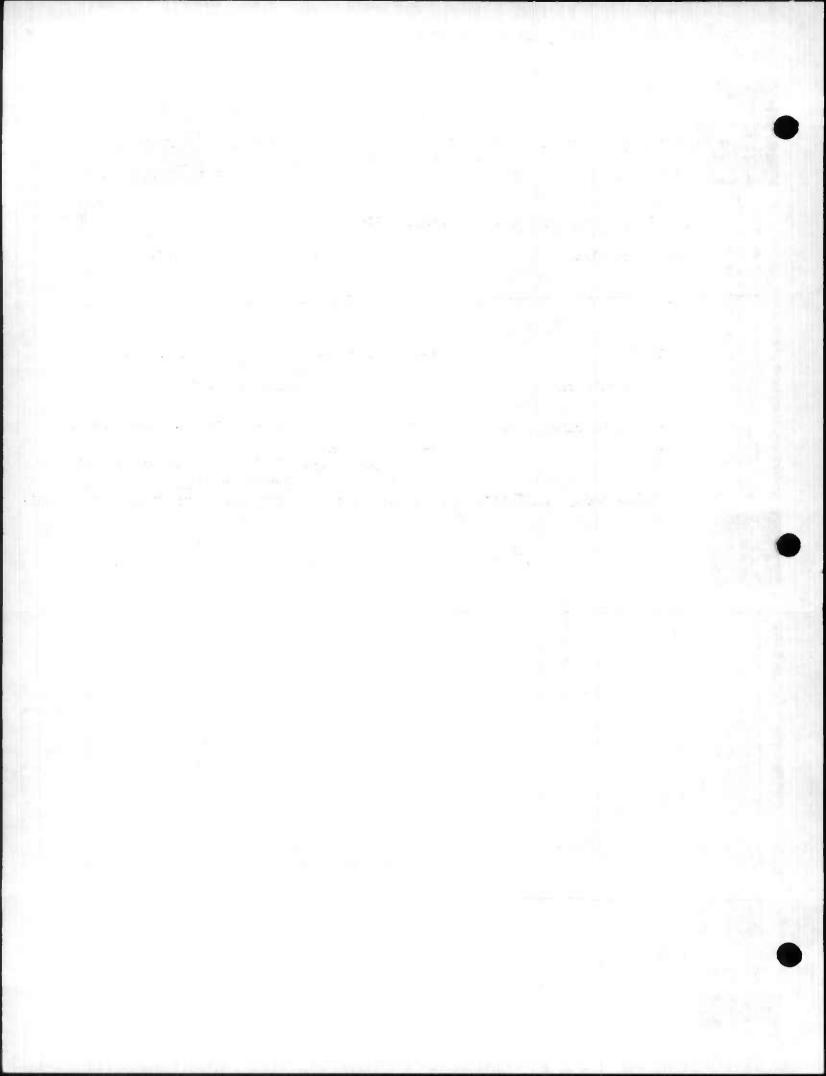
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7	filed with! Hygiene. other than	Con	12	2`		Accountar	-				ance	
/land		To Be	17. Fether's Neme (First, Middle, Last) Thomas Miller				18. Mothe		(First, Middle, N Furner	leiden Sumen	ne)	
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Į,	السالية		23e. Pert1. Enter the diseese, or compliceti shock, or heart feilure. List only one c	ons thet caused the	e death. Do n							Approximete nterval Between
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	176		30. Neme end address of person who compi	eted cause of deeth	(item 23e) (T	ype, Print)				013		
)		Ashvin J. Patel, MD P 31. Dete flied (Month, Day, Yeer)	reston Squa	re 2 6	Industrial	Park Dr.	Wal	dorf, MD	20602		
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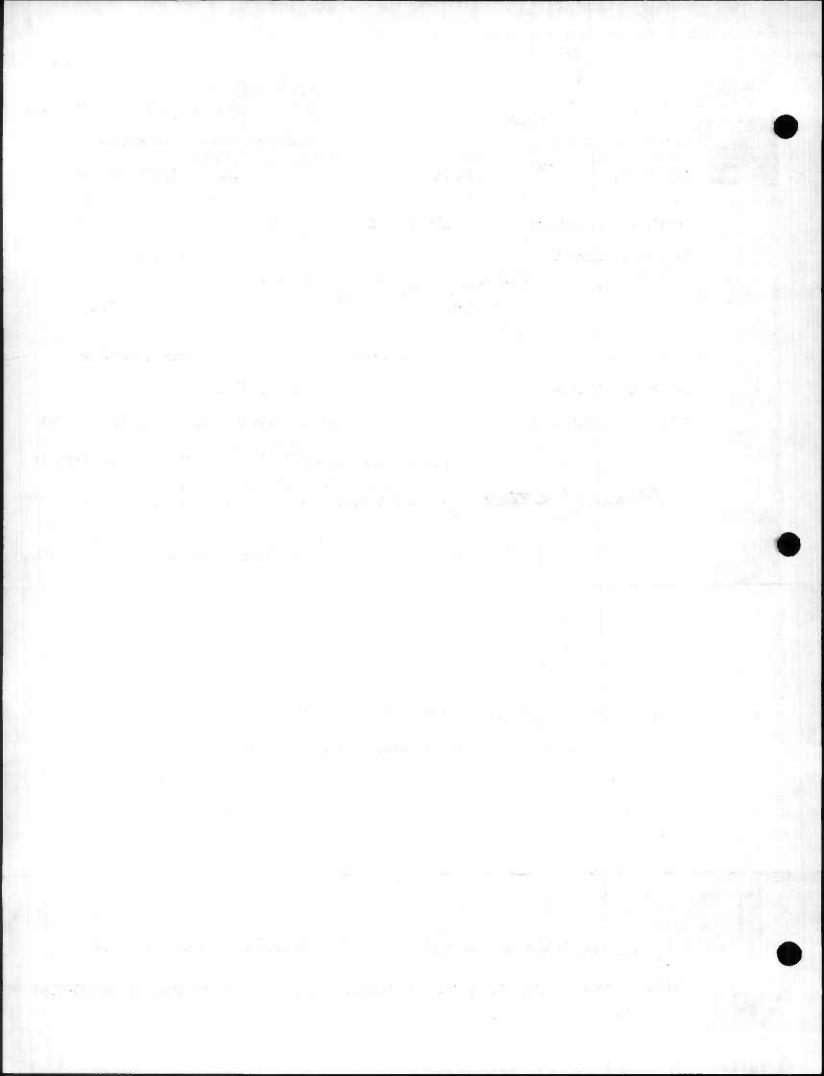


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	こまなす		Juliet F. Mart	in, Wife		1806 M	ſadre Str	eet, S	ilver Spr	ing, Ma	rylan	d 20903
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	To the HospitaLor Attending P within 24 hours efter death To the Funeral Director: After the completely filled jetty, he funeral	edical Certification:	29e. Certifier (Check only one) Certification 2 Medical Medica	fying Physician: To the cal Examiner: On the b end mer	pasis of	examinetion end/or inve	occurred et the timestigation, In my op	ne, dete end pl pinion, deeth o	ece, and due to the courred et the time	ceuse(s) end , date end place	menner as s e, end due te	teted. the ceuse(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month LLIAN KATHERWE DIEVICA EUZABETH 1998 1)3 02 /Medical 4e. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Meridian Harford Rd., Nursing Center Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 10M XF Yrs. 212-09-3148 95 Director Feb. 26,1903 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 608 Meadow Avenue 21206 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ŽONo If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify. Specify: White b 3 Widowed 4 □ Divorced Completed 1 and 2 should be filed within 72 he Heelth and Mental Hygiene. em 27 is marked other than "natur kther traumatic event, the Modical 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Department Store 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick E. Lassahn Anna Mary Elizabeth Doenges 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Heelth e If item 27 is or other tra W. Earl Hess, Jr./Grandson 2816 Fallsmont Drive, Fallston, MD 21047 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ☐ Buriel 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Crematory 3-4-98 Baltimore, MD 22. Name end Address of Fecility CAFA - Stephen D. Lohrmann, P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

8717 Green Pastures Drive, Baltimore, MD 21286
Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical ASPIRATION PNEUMONIA Examiner Due to (or es e consequenca of): Examiner DYSPHA GIA Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medicai Due to (or es e consequence of) 98 for Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? o 1 Yes 2 No 3 Probably 4 Unknown Atheroscleros Records. þ been signe should be Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evailable prior to completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To of 27. Menper of Deeth 28e. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After Division or Attanding 1 Maturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after deat Director: 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 Homicide A 24 hou. 29a, Certifier (Check only one) 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end pleca, end due to the ceuse(s) end menner es stated. Medical To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 216619 March 3, 1998 aucourances. 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) BALT. UD. 21231 · VERGARA-SOARES 100 N BROADWAY ST. 31. Dete filed (Month, Dey, Year) 32. Pegistrar's Signeture State the Davidson-Randell

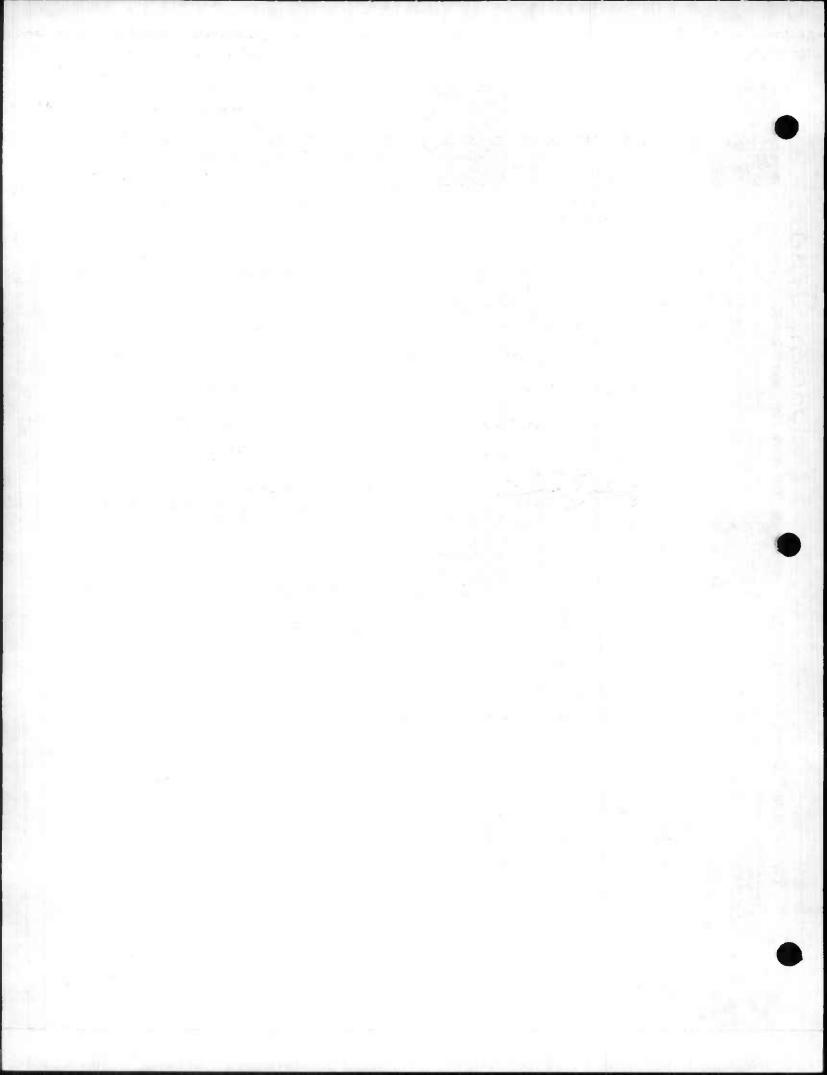
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M Meri	ဥ	19e. Informent's Neme/Relationship			19b. Mailin	a Address	(Street e			Sural Route Number, City or Town, Stata, Zip Code)				
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within 24 hours after dealt. To the Funeral Director: completely filled in by the	W	29b. Signature end title of certifiar 30. Name end eddress of person with the control of the co	m				1)	73736	2	3/	5/58			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ™ 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month Voa inkett 11/bert 1:06 AM FEB 1998 48 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Irvington Knoll Care Center Baltimore 8. Date of Birth (Month, Day, Year) Apr. 16,1924 If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 217-18-6794 Yrs Director Maryland Usual Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Exaction naist be nutified at Director 1 X Yes 2 □ No Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò Herns 23a 22 South Athol Avenue Funeral 21229 12. Was Decedent Ever in U,S. Armed Forces?

½ Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Haalth end Mental Hygiena. Important: If Itam 27 is marked other than "natural", or hearth injury or other traumete. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No þ Specify: Black 3 Widowed AD Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad) 15. Decedent's Education (Specify only highest grade completed) 16b. KInd of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Laborer Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Grandison 22 South Athol Avenue Balto.MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 Burlal 2 Cremation 3 Removal from State 3/4/98 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Mt Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall W Jones, Jr Funeral Home PA 4101 Edmondson Ave Baltimore, MD 21229 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on fich line. Approximate Interval Between Onset and Deeth **Physiclan** /Medical Immediate Cause (Final & months Capcinoma disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner plural USSICO) 11 Malignant physicien and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): P.O. Box 68760. CIMPORT 4 45 Physician/Medical Due to (or as a consequence of 98 ettending p 10468 Hypermalon Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, by Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 No 1 ☐ Yes 2 No this cartificate of Vital or Attanding Physician: 25. Was case referred to medicat exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 27. Manper of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Division After 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital of within 24 hours of To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifler 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 312198 D30494 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmare MD VIRRO K. DESAING 4660 wilkons AVE

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State

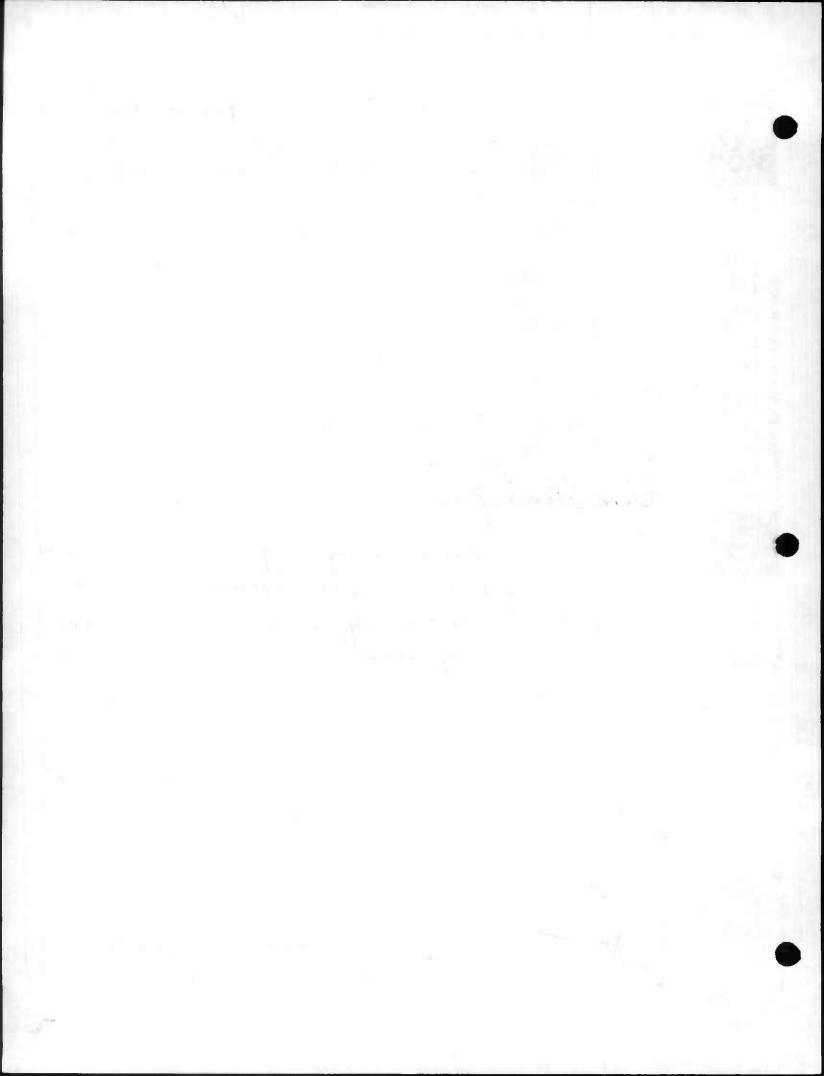
Registrar

31. Date filed (Month, Day, Year)

MAR 06 1998

32. Registrar's Signature

The Davidson



Please Type or Print in Black Indelible Inl. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month 700 Mary Parr 1. 03 03 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Multi-MEdical CEnter Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Deys Hours Min. (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (Stete or Foreign Country) **Funeral** 1□M 2×F Deys 217-24-6488 Yrs. 82 Director July 10, Maryland Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò Itsms 23a 21286 211 Garden Road U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Reca - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 "natural", or Specify: White 1 ☐ Yes 2 ☑ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry s end Mentel Hygiene. Is marked other than Elementary/Secondery (0-12) College (1-4or 5+) 10 years Cafeteria Worker High School 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surneme) Be Charles Terry Bernadette 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health elimportant: If Item 27 is any injury or other traconce. George T. Parr (husband) 211 Garden Road Baltimore, Maryland 21286 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Locetion - City or Town, Stete 1 Burlel 2 □ Cremetion 3 □ Removal from Stete 4 □ Donetion 5 □ Other (Specify) New Cathedral Cemetery 3-7-98 Baltimore, Maryland 21. Slaneture of Funerel Service Licenses 22. Name end Address of Fecility Mitchell-Wiedefeld Home, Inc. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting In deeth) Examiner Due to (or es e consequence of): Examiner Arres tach The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury ihet initiated events resulting in deeth) Lest Due to (or es e consequence of): 3140 Division of Vital Records, P.O. Box 68760, lears Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by cate has been significant page 2 should b 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? this certificate 210 No To the Hospital or Attending Physician: director, 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Delatural death 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) within 24 hours after d To the Funeral Officer completely filled in by 4 Homleide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end manner stated. 29a. Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Medical

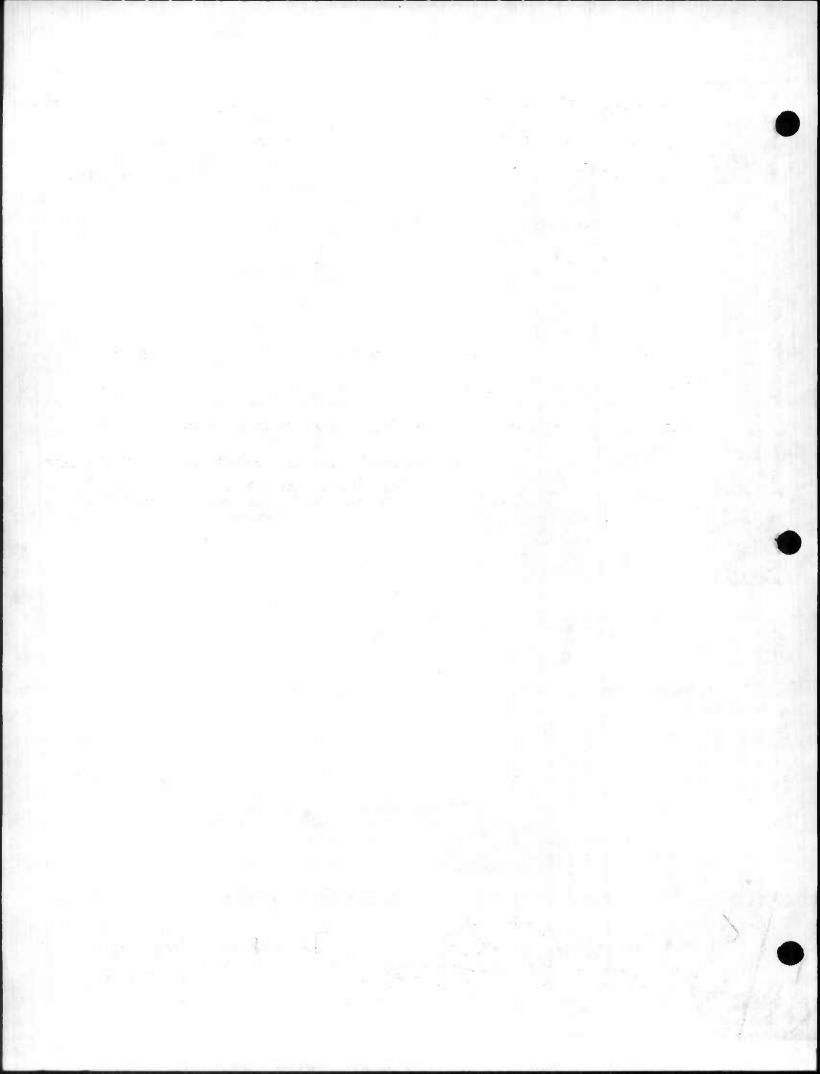
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1998 Registral's signellare of the Navidson

Id Court

Registrar

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 3. Time of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 22, ^{Day} 1998 Month FEB. RUBIN 10:15 AM 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Nema (If not institution, give street end number) BALTIMORE OWINGS MILLS 40 WOODHOLLOW COURT 5 Sociel Security Number 7. Age (In yrs. last birthdey) If Under 1 Year Hours Min. Birthplaca (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Year) Months 1 □ M 2 🖫 F Days 213-34-7481 Yrs OCT.20,1936 6 Usuel Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes WNo BALTIMORE BALTIMORE MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21215 U.S.A. 5 COBBLESTONE COURT #T-2 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Rece - American Indien. Bleck, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 Widowed 4XX Divorced 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondery (0-12) 12 OFFICE MANAGER NIGHT LAUNDROMAT 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) ALBERT BUCKOWITZ FRIEDA **JACK** 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) 21117 MARCI RUBIN / DAUGHTER 40 WOODHOLLOW CT. OWINGS MILLS, MD 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Othar (Specify) CHIZUK AMUNO ARLINGTON 2/24/98 BALTIMORE, MD 21. Signeture of Funerel Servica Let 22. Neme end Address of Facility Sol Levinson & Bros., 8900 Reisterstown Road Pikesville, MD 21208 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dylng, such as cardlec or respiretory errest, shock, or heart failure List only one ceusa on each lina. Approximete Interval Between Onset and Deeth AND LUNG CANCER Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequenca of): Dua to (or es a consequance of): 23b. Did tobacco use contribute to the cause of death? 2 No Yes 3 Probably 4 Unknown 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24e. Wes an eutopsy performed? 1 Yes 1 TYAS 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one)

Physician /Medical Examiner

tha daath certificate be axecuted

Box 68760

Division of Vital Records, P.O.

Physician

/Medical

Examiner

10e State

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinal must be notified at

other 1

Department of Important: If eny Injury or phose. Injury or

Pages 1 and 2 should be filed within 72 hours effer onent of Health end Mental Hygiena. Int: If Item 27 is marked other than "natural", or Iter

3altimore, Maryland 21215-0020

with the Meryland

death

Examiner buriel-transit and physician the 80 950 ö signed by I has page 2 certificata Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certific. funeral Certification:

Medical

State

Registrar

Physician/Medical by Completed Be 2

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

2 ER/Outpatient 3 DOA 1 Inpatient 28a. Dete of Injury (Month, Dey Year) 28b. Time of 5 Pending investigation Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 28d. Describe now injury occurred

28c. Injury et Work? 1 Yes 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

5 Desidence 6 Other (Specify)

29a. Certifier (Check only one)

1 Yes

27 Manner of Deeth

Neturel

2 Accident 3 Suicida

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred et the time, date end placa, end due to the ceuse(s) end manner as stated.

In the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner steted.

In the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner steted.

29b. Signature and title of cartil

6 Could not be determined

29c. Licansa number

29d. Date signed (Month, Dey, Year) 2 /23 /98

30. Name end eddress of pe who complet d cause of deeth (Item 23a) (Type, Print) UTE 200 UTHERVILLE, MD 10755

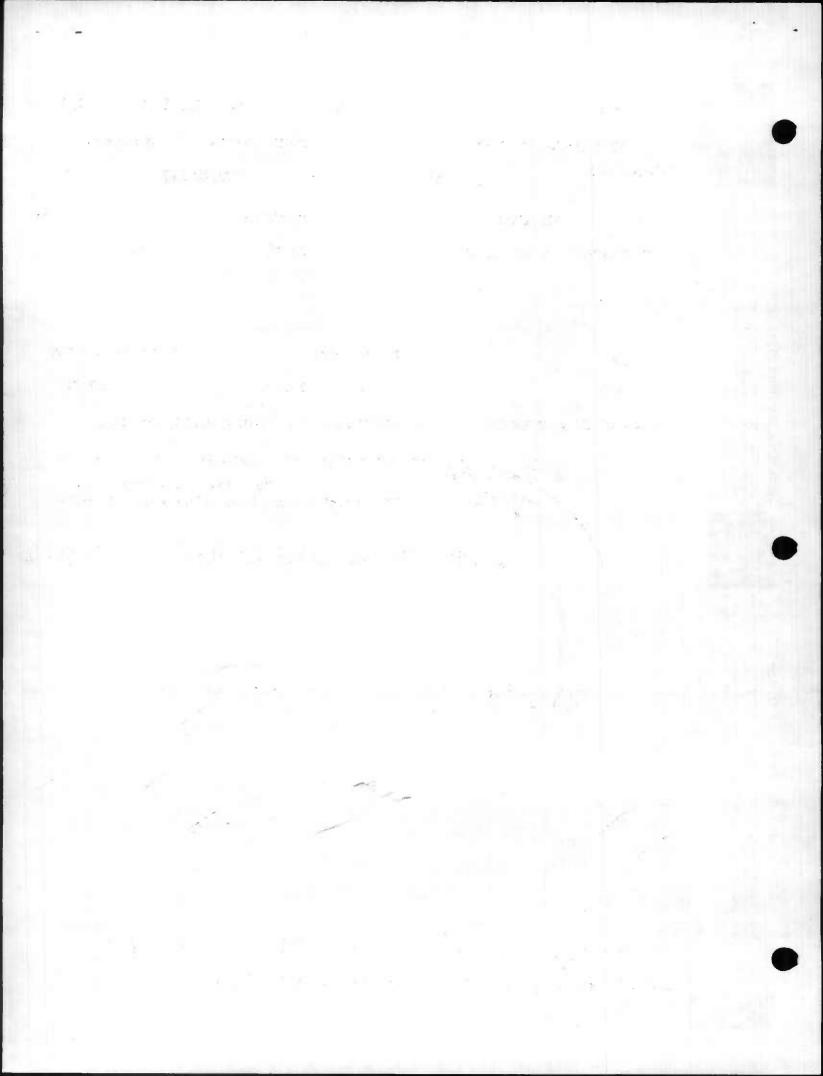
31. Date filed (Month, Dey, Year)

MAR 06

32. Registrer's Signeture Julia Davidson

DHMH 16 Rev 6/95

within 2 To the F



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\infty \) Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month John 10.28 1998 Mar 4a. Fecility Nama (If not institution, give streat end number, 4b. City, Town, or Location of Daath 4c. County of Death Itimore tospita Center Ba arbor N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 100 M 2□ F 215 09 9576 Aug. 11, 1915 Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥EYas 2□ No N/A Baltimore City 10e. Straat and Numbar 10f. Zip Coda 10g. Citizen of What Country? 1306 Towson Street 21230 United States 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, atc. Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 1 ☐ Never Married 2 ☑ Marriad l □ Yas 2X No If Yas, Giva Yaer or Detas: 1 ☐ Yas 2 No Specify: White Specify: 3 Widowad 4 Divorced 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Educetion (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamantary/Sacondary (0-12) Collaga (1-4or 5+) 8 N/A Shipyard Worker Manufacturing 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fether's Neme (First, Middle, Last) Thomas Ryer Frances Sakosky 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1306 Towson Street Frances N. Ryer/ Wife 20b. Place of Disposition (Nama of camatary, crematory or other place) 20a, Mathod of Disposition 20c. Location - City or Town, Stata Nation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Spacify) Glen Haven Memorial Park March 9,1998 Baltimore, Maryland 21. Signatura of Funeral Sarvice Licensea Victor P. Doda, Jr. 22. Nama and Address of Fecility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore Maryland 21230 23e. Pert1. Entar the diseese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervel Batwaen Onsat and Daath Immediete Causa (Final METASTATIC NASOPHARYNGEAL CARCINOMA 3 YEARS disaasa or condition rasulting in daath) Dua to (or as a consequence of) Dua to (or as a consaguance of): Dua to (or as a consaquance of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Nos 2 No 3 Probably 4 Unknown DEHYDRATATION 24b. Wara autopsy findings evellebla prior to completion of cause of daath? PNEUMONIA 24a. Wes an autopsy performad? 2 M No 1 ☐ Yes 2 ☐ No 26. Placa of Daath (Check only ona)

Physician /Medical Examiner

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After

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To the Hospital or Att within 24 hours after of To the Funeral Direct

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Completed

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Certification:

Medical

P.O. Box 68760.

Division of Vital Records,

Physician:

Physician

/Medical

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permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Health and Mental Hygiene.
Important: If term 27 Is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Experies may be notified at

Baltimore, Maryland 21215-0020

Examiner Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Disaasa or Injury that initiated evants rasulting In daath) Last Physician/Medical

> 25. Was casa rafarred to madical axaminar? 1 Yas 2 No

2 ER/Outpatient 3 DOA

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify)

27. Mannet of Death 1 Naturai 5 Panding invastigation

28a. Data of Injury (Month, Day Year) 6 Could not ba

1 Inpatiant

28b. Tima of 28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

29a. Certifiar (Check only one)

2 Accidant

4 Homicida

3 ☐ Suicida

The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and fittle of certifiar

29c. Licanse number

29d. Date signed (Month, Day, Year) AG 244 1614 MARCH 5, 1998

31. Data filed (Month, Day, Year)

30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print)

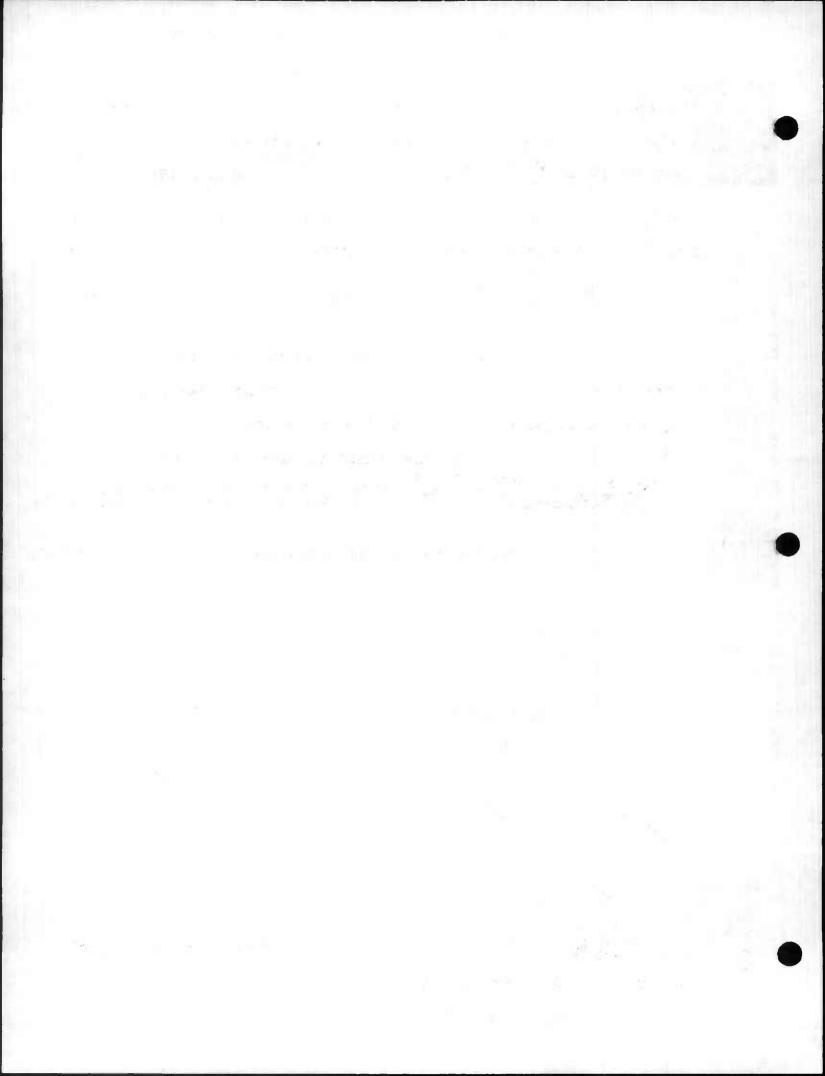
KAMLER, MD HARBOR HOSPITAL CENTER, BALTIMORE

Location (Street and Number or Rural Route Number, City or Town, Stata)

State Registrar



28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Month February 25, 1998 12:36 P.M. DEBRA D. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel General Hospital | If Undar 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year Universely) | Min. | 3, 1 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 1 M 200 Brooklyn, NY Yrs 1936 Director 134-28-7297 Usual Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits worle 7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Modical Examiner must be notified at MXYes 2□ No Gambrills Maryland Director Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with U.S.A. 21054 Tabor Road 2338 Mt. Funeral 12. Was Decadent Ever in U,S Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after to Department of Health end Mentel Hygiene. Important: If Itam 27 is marked other than "natural", or iten eny Injury or other traumatic avant 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Naver Marriad 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Years Bookkeeper 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Meyerson 10 Irving Finkelstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2338 Mt. Tabor Road, Gambrills, Maryland 21054 Michael H. Ross, Husband 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 2/27/1998 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden Falls Church, VA 21. Signeture of Funeral Service Licansee 22. Name and Address of Facili STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012 us. 23a. Part1. Enter the disease, or complications that caused the peath. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medicai Immediate Causa (Final IMMEDIATE a. CARDIO PULMONARY ARREST diseese or condition resulting in deeth) **Examiner** Due to (or es e consequence of) Examiner MANY YEARS HYPERTENSION attending physicien end for use es the burial-transit Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. MANY YEARS c. ASAD Physician/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detact 1 Yes XX No 3 Probably 4 Unknown DIABETIS MELLITUS Records, by should I 24b. Were sutopsy findings available prior to Completed 24a. Was an eutopsy HYPROTHYROIDISM, HAD RECENT CVA - CEREBRAL VENTICULAR completion of causa of death? page 2 certificate hes 1 Yas 2 No 1 ☐ Yes 2 ☐ No Chausafter death. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2K No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, straet, factory, offica building, etc. (Specify) 6 4 - Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier within 24 be To the Function Medical 29c. Licansa number 29d. Date signed (Month, Dey, Year) 29b. Signature and cartifier We warred D04827 February 26, 1998 30. Neme and ag of person who completed cause of death (Item 23a) (Type, Print)

3450 Fort Mead Road, Suite 209, Laurel,

Maryland

Registra

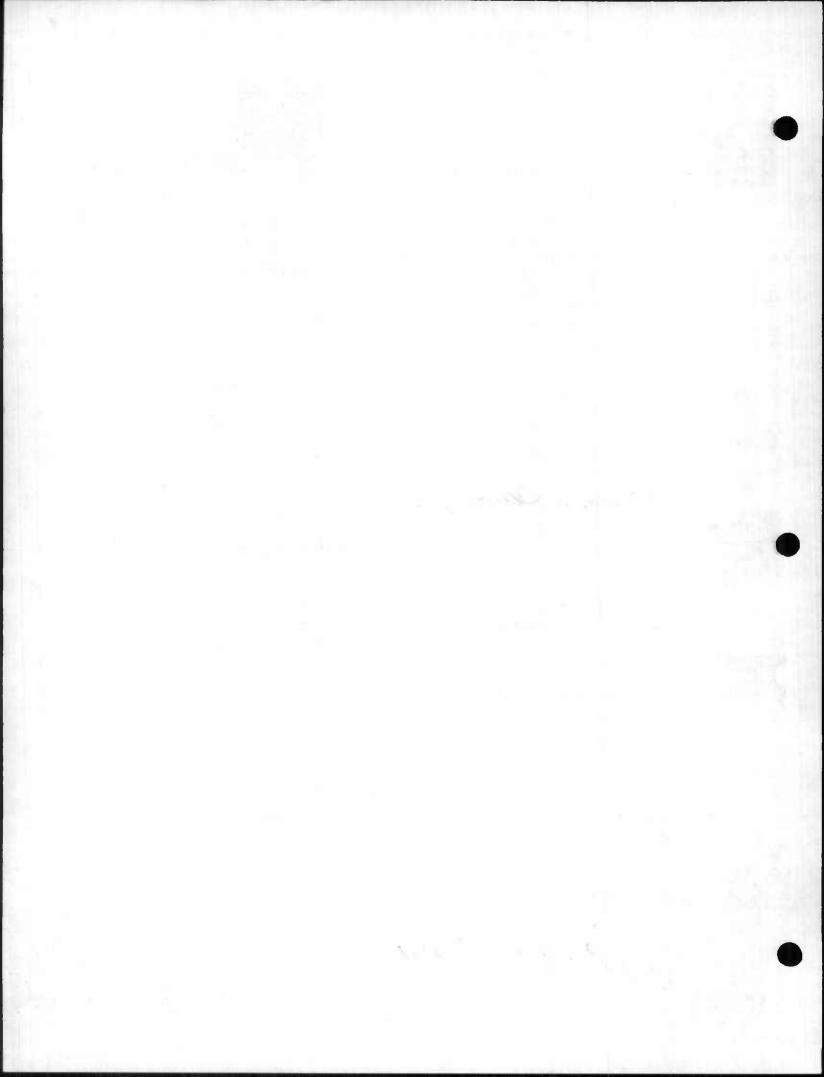
State

Jon Mariano, M.D.,

22. Registrar's Signature

Davidson-Randall

31. Date filed (Month, Day, Yeer)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March John George Smith 10:00PM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner East Point Nursing Center Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 1909 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₩ M 2□ F 89 Maryland 215-05-3594 Yrs. **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count Maryland Baltimore **Fssex** 1 Yes X No r than "natural", or items 23s or 28s-f s the Medical Examiner must be notified Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1500 Pattison Road 21221 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White py 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 2 should be filed within 72 and Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Clerk U.S. Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) George Smith Marie Denk 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 4 1 and 2 st of Health av A flam 27 br Donald J. Smith (SON) 1500 Pattison Avenue Essex, Md. 21221 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ■ Burial 2 □ Cremation 3 □ Removal from State ò Lorraine Park Cemetery 3/7/1998 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 23a. Part 1. Enter the dillease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shrick, or heart failure. List only one cause on each line. 1407 Old Eastern Avenue Essex, Md. Approximete Intervel Between Onset and Death **Physician** /Medicai Immediate Cause (Finel disease or condition resulting in deeth) Examiner EBROVAS CUZAR
Due to (or as a consequence of): Examiner physician and the bunal-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last THEROSCLEROTIC CARDIDVASULAR
Due to (or as a consequence of):

DISEASE P.O. Box 68760. Physician/Medical 88 LABETES use. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohacco use contribute to the cause of death? DEPRESSION 1 Yss 2 No 3 Probably 4 Unknown of Vital Records. þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has b lirector, page 2 s 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred Certification: 28a. Date of Injury (Month, Dev Year) 28c. Injury at Work? Division Ananding 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident ector: 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 8 24 hours 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner es stated. (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

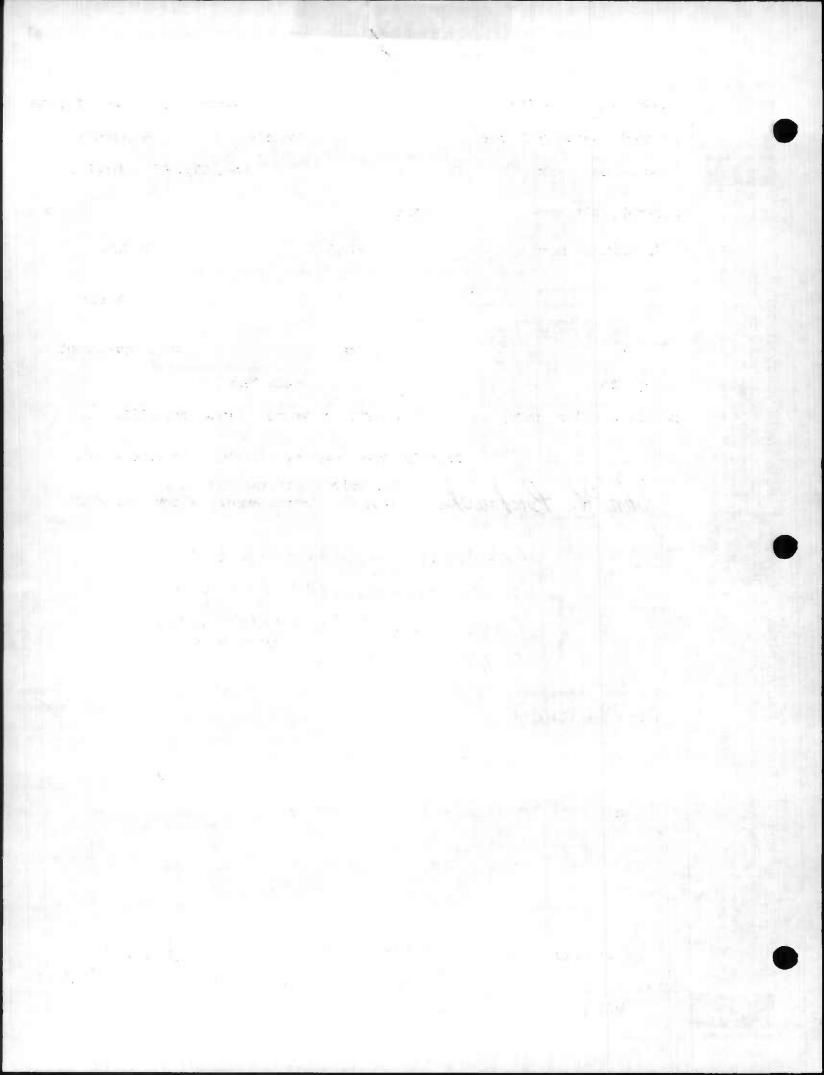
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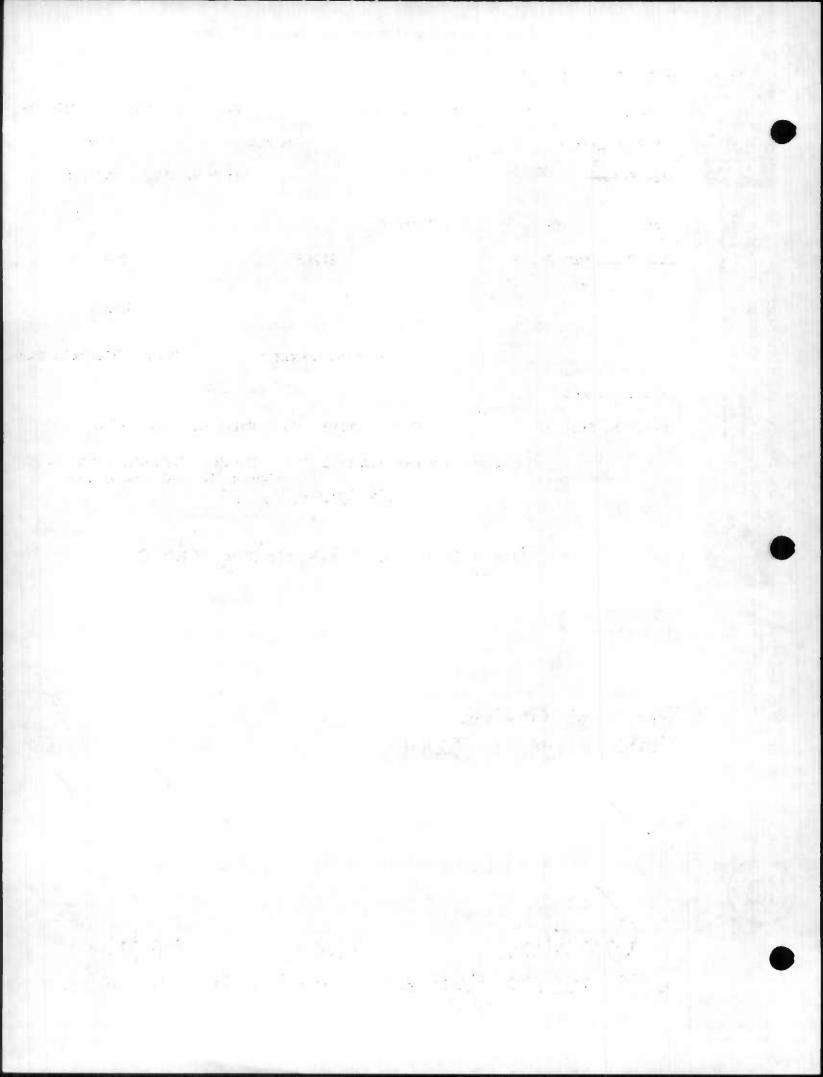
1998

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cause of death (Item 23a) (Type, Print)



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caminer	Luther Be	ernard		ige, S	Sr.	4h City Town	2. Date of De Month Feb or Location of Death	27, 19	Year 98 3	e of Death	
	The country of the country of the country		noer)					4c. County	n/a		
	2836 Pressbu:		7. Age (In yrs. I	ast hirthday)	If Under 1 Year		imore Irs. 8. Date of Bir	th	9. Birthplace (Sta	ate or Foreign	
ral or	5. Social Security Number 6 3 2 / A 213–18–1923	100 M 2□ F		74 Yrs.	Months Days	Hours N	March 5	ay, Year)	Country) Marylai		
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	10a. State 10b. Count	у	10c. City	, Town or Lo	cation					le City Limits	
Funeral Director	MD	n/a	Ba	1timor	е		2.5		1 🔯	Yes 2 No	
	10a. Street and Number				10f. Zip Code			10g. Citizen of V	What Country?		
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2	11. Marital Status	12. Was Dece Amed Fo	dent Ever in U,:	S. 13. V	Vas Decedent of f Yes, specify Cub	Hispanic Origin?	(Specify Yes or No Jerto Rican, etc.)		e - American India ck, White, etc.	n,	
l	1 ☐ Never Married 2 Ma	rried 1 X Yes	2 No		I Yes 3∏ No	Specify:		Specify			
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1	17. Father's Name (First, Middle), Last)			Machine		Y Name <i>(First, Middle</i>		n Electr	ic corp	
							KNOWO	,			
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ŀ	Carrie M. Str.	ange	20b. Pi	lece of Dispo	Pressbur sition (Name of		Baltimor		21216 City or Town, Stat	te	
l	1 ☐ Burial 2 ☐ Cremation		State		natory or other pla		26				
	4 □ Donation 5 ② Other (ment Ar		Memorial		March 4		ore Coun		
l	21. Signature of Funetal Service		1					ieral no	mes, inc	•	
	2501 Gwynns Falls Pkwy Baltimore, MD 21216										
	shock, or feart failure. List only one ceuse on each line.										
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	Immediate Cause (Final disease or condition resulting In death)	a lur	19 CAY	NCEX	5 - K	espira	toly to	ailuse			
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1	if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	С									
	resulting In death) Last		Due to (or	as a conseq	uence of):						
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1	Part II, Other significant condit	lane contribution to de	nath hut not soon	Iting in the	adadvina sauss s	iven in Part I	22h Did	tohacco use co	ntribute to the co-	use of death?	
	raitii, Other significant condit	CONTRIBUTING TO de	out not resu	inting in the Ur	idenying cause g	venini Fan I.				/	
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	CHARRET	MARIE	To	51.1					24b. Were auto	psy findings	
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-	05 W	-1						(1 Li Yes	LINO	
1	25. Was case referred to medic examiner?	Hoenital:			-= 0	ther:	Death (Check only	tobacco use contributa to the cause of death? Yes 2 No 3 Probably 4 Unknown s en autopsy ormed? 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No one) idenca 6 Other (Specify) how Injury occurred (Street and Number or Rural Route Number, wm. State) ceuse(s) end manner es stated. dete end placa, and due to the cause(s)			
1	1 Yes 2 No 27. Manner of Deeth	101		ER/Outpatien 28b. Time of	T 3LI DUA	4 LI NUISIN	-				
-	1 Natural 5 □ Pend	ing (Mont	of Injury th, Day Year)	Injury	W	ork? ☐Yes 2☐No	200. 1000100				
1	3 ☐ Suicide 6 ☐ Could	1 - 11 -	of Injune At ho	me form str			28f Location	(Street and Numl	her or Rural Route	Number	
	4 ☐ Homicide deter	mined 286. Place buildin	ng, etc. (Specify)	eet, fectory, office		City or To	wn, State)	or or ribiar riouto	140111001,	
ŀ	29a, Certifier Certify	ing Physician: To the	heat of my know	uladaa daath	accurred at the t	ime date and o	loce, and due to the	coura(e) and me	anner se eleted		
- 1		I Examiner; On the ba	asis of exeminet							use(s)	
	A		ner stated.		29c. Licer	nse number		29d. Date signe	d (Month, Day, Ye	er)	
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	> Lana	stran)		026	003	100	314	98		
	> Lana	n who completed caus	e of death (Item	23a) (Type,	Print)	4003	1118	3141	21002		
	> Lana	URD	e of death (Item SWTE pgistrar's Signal	= 20c	Print) hus	HERV	IUF	3141 mp	21092)	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Deta of Death **Physician** STEINBRECHER ROBERT FEBRUARY 1350 /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHURCH HOME HOSPITAL BALTIMORE Hours Min. 8. Data of Birth (Month, Day, Year)
JUN 22 1939 5. Social Sacurity Number If Undar 1 Year 7. Aga (In yrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** 1⊠M 2□ F 57 Yrs. Director 383-36-2509 MI Usuai Rasidance of Dacadan 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2□No Director 288-7 N/A BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 8 8 2032 EAST BALTIMORE STREET USA 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yas 2 No Specify: þ Specify: 3 ☐ Widowed 4 ♣ Divorced WHITE Be Completed 15. Decedant's Education (Spacify only highast grada complated) 16e. Dacedant's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work dona during most of working lifa. DO NOT usa ratired) Elementery/Secondery (0-12) College (1-4or 5+) the 12 LABORER CONSTRUCTION 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumame) JOSEPH STEINBRECHER ANNA REICHHARDT 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straet and Number or Rural Routa Number, City or Town, State, Zip Coda) CYNTHIA L. STEINBRECHER 4248 SYLVANIA RD., PETERSBURG, MI 49270 20a, Mathod of Disposition 20b. Placa of Disposition (Neme of 20c. Location - City or Town, Stata BALTIMORE WASHINGTON = 6 1 Burial 2 Cramation 3 Ramoval from Stata LAUREL, MD 4 ☐ Donation 5 ☐ Othar (Specify) 3-5-98 CREMATORY 21. Signature Funarai Sarvice Licensaa 22. Name and Address of Facility
STERLING ASTHON FUNERAL HOME, INC. 736 EDMONDSON AVE., BALTIMORE, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. **Physician** /Medical Immediata Causa (Final THALAMIC AND CEREBGUAR INFARCT 2 weeks disaasa or condition rasuiting in death) Examiner Dua to (or as e consequance of) Physician/Medical Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Box 68760. 100 Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Leumonia Records. by 24b. Wera sutopsy findings evailable prior to Completed 24e. Was an eutopsy performed? complation of causa of death? 1 Yas 2 No 1 Yas 2 No Vital Be 25. Was casa refarred to medical 26. Placa of Daath (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 10 of this 27. Menner of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Division 5 Panding invastigation 1 Netural Hospital or Attendit 124 hours after death. Funeral Director: Af 2 Accident 6 Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end dua to tha cause(s) end manner as stetad.
2 Medical Examiner: On tha basis of axamination end/or investigation, in my opinion, daath occurred at the time, deta and place, and dua to the cause(s) and manner stated. 29a, Certifian Medical within 24 hor To the Fune the 29b. Signatura and title of certifiar 29c. License number D 40 357/ 29d. Date signad (Month, Day, Yaar) and Specialist WW avarue my 30. Name and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print) BACTIMORE, MARYLAND 21231

100 N. BROADWAY,

ika Davidson-Randell

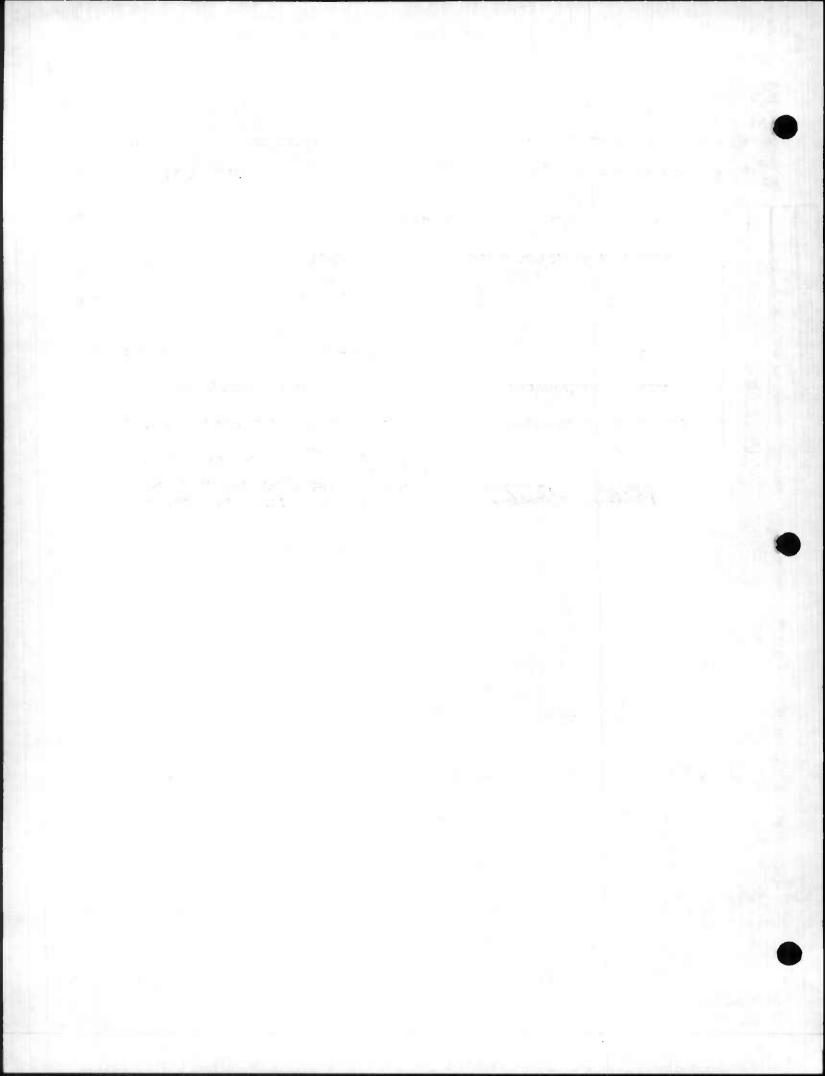
32. Registrar's Signatura

State Registrar

W. NAVARRO 31. Deta filed (Month, Day, Year)

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NAME KNOWN TO



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Sneed MANCI 35 AM Irene 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1Aryland 105PI TENERAL NA 41 If Under 1 Year 5. Social Security Numbar 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 KF 214-22-3828 73 Yrs 12-29-24 MD. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2□No Md. NA 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 123 West 29th Street Apt. #F12 21218 USA 12. Was Decadent Ever in U,S. Armed Forcas? Was Decadent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Navar Marriad 2 Marriad 1 ☐ Yes 2 ☐ No If Yes, Give X Yaar or Dates: 1 ☐ Yes 2 ☐ Nio Specify: Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 10th Grade Janitorial C&P Telephone Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Oscar Sneed Hannah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 1808 Bolton Street Baltimore, Maryland Marsha Carter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XX urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. Cem. 03-04-98 Randallstown, Md. 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death of the Colon Immediate Cause (Fina disease or condition resulting in death) Due to (or es a consequence of) exiA Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 € Unknown 24b. Were eutopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending Investigation 1 ☐ Yes 2 ☐ No

Box 68760. physicis esn Records, P.O. signed by t Completed peeu page 2 s certificate Division of Vital the Hospital or Attending Physician: thin 24 hours efter death. the Funeral Director: After this certifica mpietely filled in by the funeral director, t

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

ed other than "natural", or lierns 23s or 28s-f shor event, the Medical Examiner must be notified at

Department of Health and Mental Hygiens. Important: If item 27 is marked other than sny Injury or other transmission of the than

Physician

Examiner

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Physician/Medical

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Be

Certification: To

Medical

30. Name and addrass of person who completed cause of death (Item 234) (Type, Print

32. Registrar's Signature

Kupinder

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31. Date filed (Month, Day, Year)

/Medical

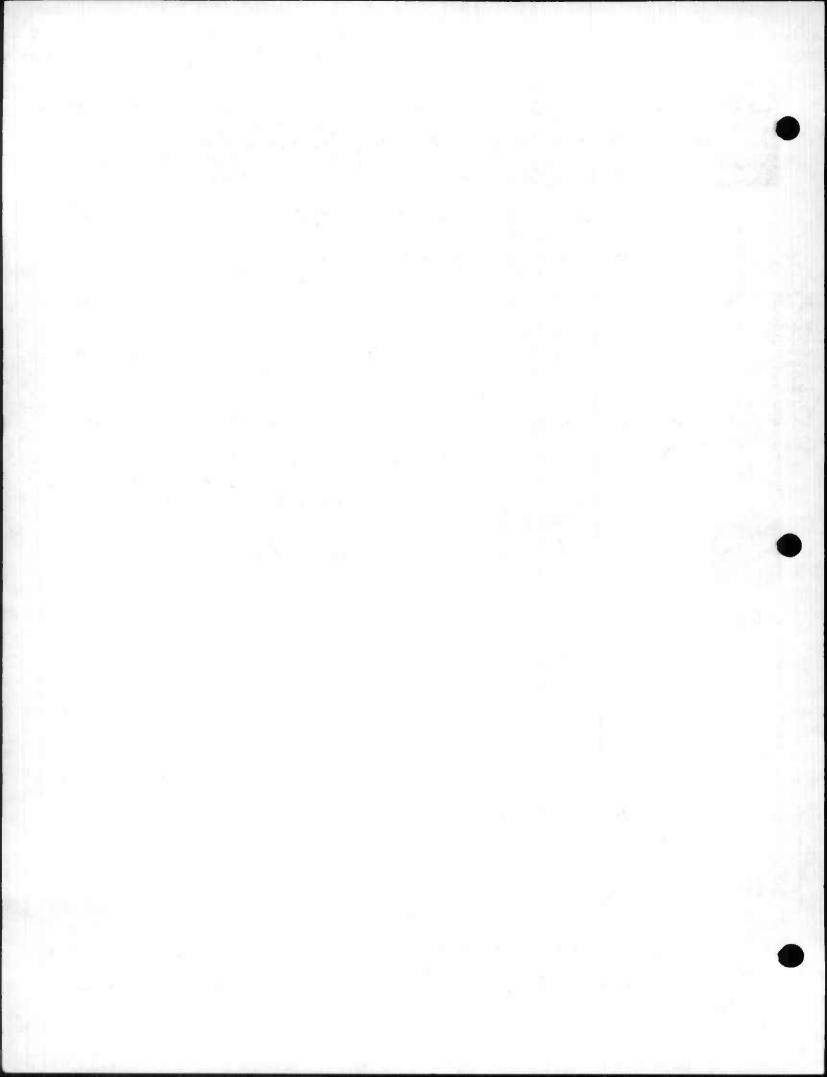
Pages 1

Baltimore,

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2DNo 27. Manner of Death 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and iffle of certifie

State Registrar

within 24 hours eft To the Funeral Dis completely filled in



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) 3:30pm Jacqueline Stafford Feb 28, 98 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) 2307 Whittier Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) 1□ M 2□ F Months Days Hours Min. Yrs. 54 09-17-43 217-40-8864 MD. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits MYes 2□ No Md NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2307 Whittier Avenue 21218 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - Amarican Indian. Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12th Grade 18. Mother's Neme (First, Middla, Maiden Surnama) 17. Father's Name (First, Middle, Last) Charles E. Gross Wright 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21216 19e. Informant's Name/Relationship (Type, Print) Kim Knox 1013 Popular Grove Street Baltimore, Md. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 03-05-98 Dundalk, Md. 22. Nama and Address of Facility 21. Signature of Funeral Service Licenses Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth 3/4 year Immediate Cause (Final Metastatia Carcinoid disease or condition Due to (or as a consequence of) Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wera autopsy findings aveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 2 No 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after deeth 1 Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23, any injury or other traumatic event, the Medical Exemples man

Baltimore, Maryland 21215-0020

Box 68760 death certificate be

Division of Vital Records, P.O.

Director

Funeral

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Examiner physician and the burial-transit Physician/Medical ed by the e signed b by Completed director, Be 2 funerel Certification: To the Hospital or Atta within 24 hours efter de To the Funeral Director completely filled in by th

peed has

or Attending Physician: effer deeth. Director: After this certifica

27. Manner of Death Naturel 2 Accident 3 Suicide 4 Homicide

Certifying Phyeicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler (Check only one)

Donot 31. Date filed (Month, Day, Year)

5 Pending investigation 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Yaar)

28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29b. Signature and title of certifiar, 1

MAR 06

29c. License number D40854

301 St Pun Pl

29d. Date signed (Month, Dev. Year)

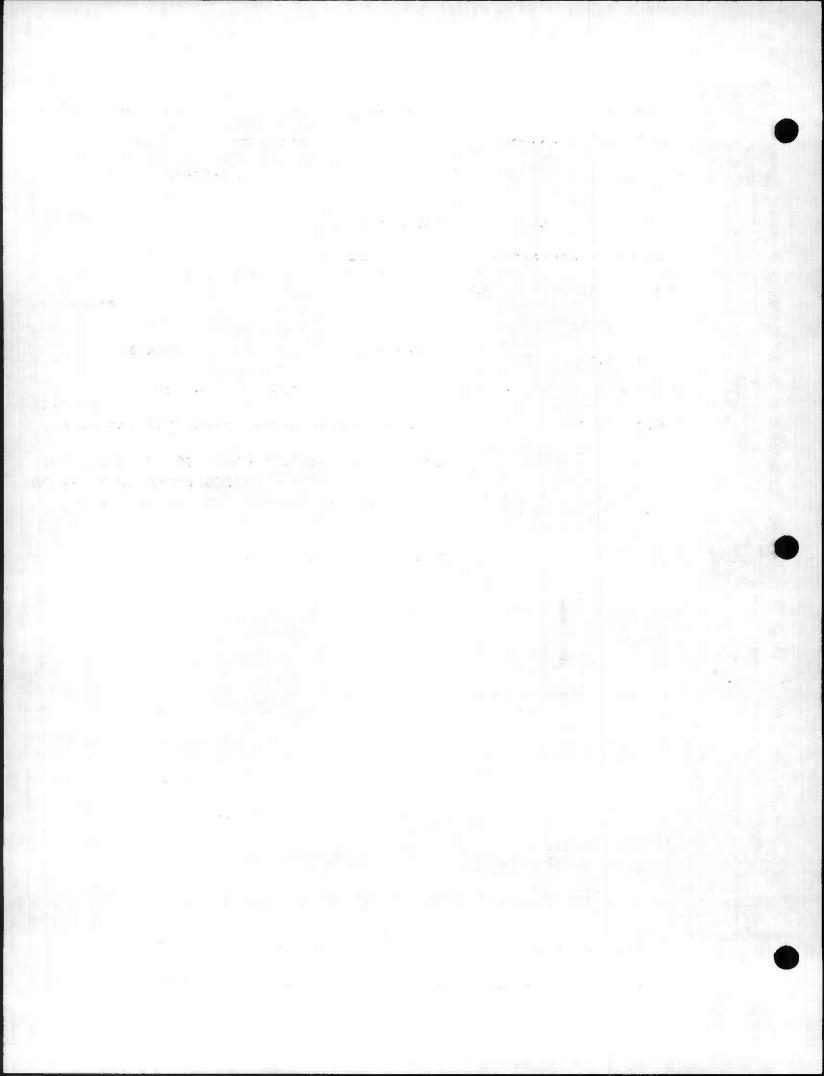
30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) - A. Risebers

Bultimer, MD 21202

Registrar

Medical

402T MD 32. Registrar's Signature una Davidson-Randell



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) ate of Death 1ARY ANNE STEVENSON 4a. Facility Name (If not Institution, give street end number) 4b. Cftv. Town, or Location of Deeth 4c. County of Death BALTIHORE EVINDALE NURSING Home NIA If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) 10 M 20 F Deys 220-36-0509 Yrs AND Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NIA MARYLAND 10a. Street end Number 100. Citizen of What Country? AVENUE USA, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Nerried 1 ☐ Yes 2 ₺ No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Decedent'a Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12+4 GRADE RESTAURANT 17. Father's Neme (First, Middle, Last) 18. Mother'a Name (First, Middle, Melden Sumeme) ERNEST JONES ARRIE 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) HUSBAND) 36 11 HAYWARD AVENUE, BALTIHORE, MD. 21215 20b. Place of Disposition (Nortle of Dete 20c. Location - City or Town, State GILBERT STEVENSON (20a. Method of Disposition 1 Buriai 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 03-11-98 OWINGS HILLS, MD. 22. Name and Address of Facility BROWN JR. FUNERAL HOME 21. Signeture of Funeral Servica Licanses 2140 N. FULTON AVE, BALTIMORE, 40. 21217 narron 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Liat only one cause on each light. Approximete intervei Between • Onset and Deeih immediate Cause (Finei disease or condition resulting in deeth) Jan. 1998 Encelha saudomonas

Physician /Medical Examiner

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Certification: To

Medical

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filled within 72 hours after of Department of Health and Mertel thygiene. Important: If New 72 is marked other than "naturel", or itse inty injury or other traumatic event, the Medical Enarment eny injury or other traumatic event, the Medical Enarment

Baltimore, Maryland 21215-0020

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death

Examiner Sequentielly list conditions, if eny, leading to immediale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

		24a. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth?
		1 ☐ Yes 20 No 1 ☐ Yes 20 No
25. Was case referred to medical	28. Place of Deeth	(Check only one)
examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 Residence 8 Other (Specify)
27. Manner of Deeth 1 Diveturei 5 Pending 2 Accident investigation	(Month, Dey Year) injury Work?	8d. Describe how injury occurred
3 Suicide 8 Could not b	28e. Pleca of injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Locailon (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifler

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) end menner stated.

29c. License number

29b. Signature and title of certifie

D23767

29d. Dete signed (Month, Dey, Year)

erson who completed cause of death (item 23a) (Type, Print)

Ma Davidson

2434 W Beliedere Ave, Balto, Md 2126 GERTHEINER MO 32. Registraris Signeture

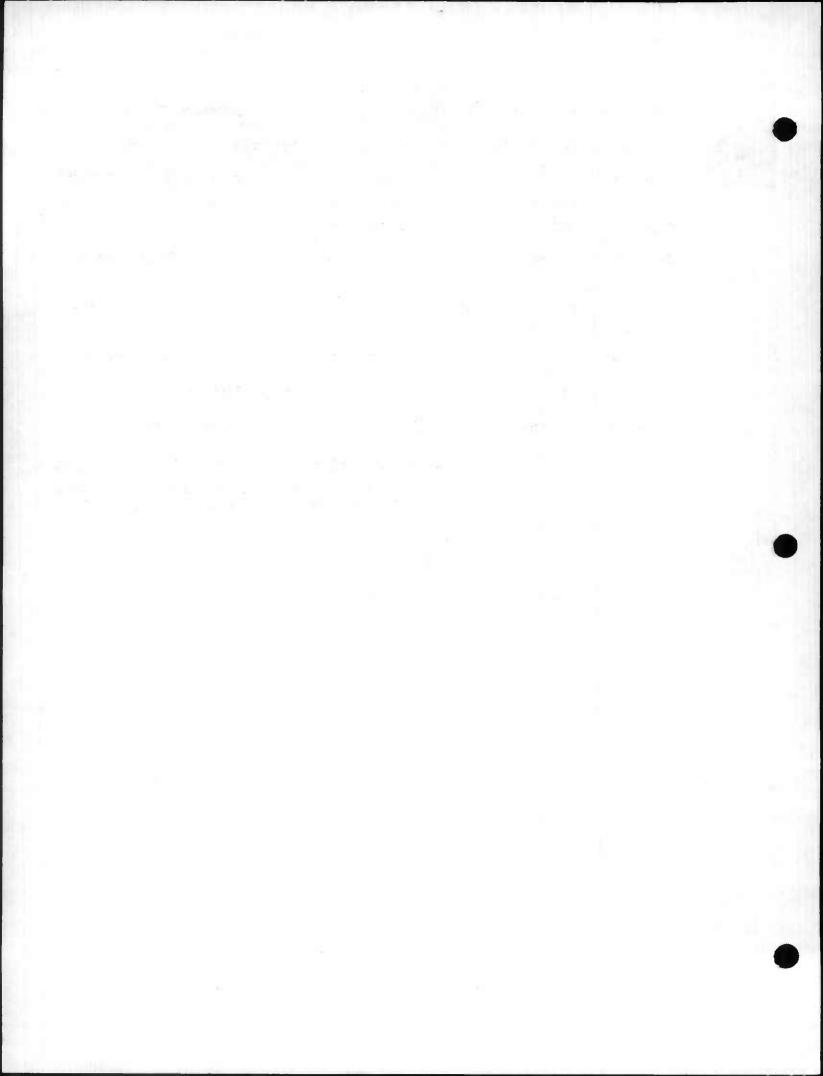
State Registrar

To the Hospital or Attend within 24 hours efter deeth To the Funeral Director:

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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and 2		Catherine Kaczon	/Daughter	257	Sheepskin	Drive We	stminst	er, Mar	yland 21157	
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pemit. E Departm Importar any injur		21. Signatura of Funaral Sarvice Li	Collin-1	while	4112 old C	litzke's F Columbia P	ike Ell	icott C	Home, Inc. ity, MD 21043	
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Physician: The this cartificata ral director, pay	To Be	25. Was cesa referred to medicel examiner? 1 ☐ Yas 2 ♣ No	Hospital:	iant 2 ER/Outp	atient 3 DOA Ott	26. Placa of Daath har: 4 Nursing Ho			an (Canada)	
Aftar funa		27. Manner of Death 1 Natural 5 Pending 2 Accident invastiga	28a. Dete of Inj (Month, D	ury 28b. Tin	na of 28c. Inju			now Injury occur		
i Die o	Certification:	3 Suicida 6 Could no datarmin	26a. Place of Ir	njury - At homa, farm tc. <i>(Specify)</i>	, straat, factory, office		28f. Location (5 City or Tox		per or Rural Routa Number,	
Ne Hospital n 24 hours Ne Funeral pletaly filled	edical	29a. Cartifiar (Check only one) Certifying 2 Madical Ex	Physician: To the best aminar: On the basis of and manner s	of axamination and/o	leath occurred et the ti or investigation, in my c	ma, data and place, a opinion, deeth occurre	and dua to the e	ceusa(s) and ma date end plece,	annar as stated. end dua to tha causa(s)	
To the within 2 To the comple	M	29b. Signeture end titla of certifiar			29c. Licens			29d. Data signe	d (Month, Dey, Year)	
DA		1 stor you	uns		0-3	N 66 8		Amul	5/1898	
5			55 LUTL	3 patent	pe, Print)	olunbis,	MuD	21.44	c	
Sta Registr		31. Date filed (Month, Day, Year) MAR 0 6 1998	32. Ragion	rar's Signature VIdoon—Internolo	90					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Item#7,8, perFH G758 4/2/98_{EW} State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 19b per FH G-757 3/6/98 dh Reg. Nő 1. Decedant's Nama (First, Middla, Last) 2. Data of Death

Physician /Medical Examiner

> **Funeral** Director

7 is marked other than "naturely, or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at Items 23a hours efter death "naturel", or Pages 1 end 2 should be filed within nent of Health end Mental Hygiene. mt: If item 27 le marked other than "

JURGUY, ANDREW

Department of Health e Important: If item 27 le eny injury or other tra **Physician** /Medical Examiner

requires that the death certificete be executed ettending physician and for use es the buriel-tran Division of Vital Records, P.O. Box 68760 the signed by the peen The law has e 2 16 certifica Hospital or Attending Physician: 24 hours efter deeth. director, this After this funerel

Director Funeral à Completed Examiner Physician/Medical p Completed Be

Month ANDREW R. SURGUY 2, 1998 March 4c. County of Deeth 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva straat and number) Baltimore Franklin Square Hospital Center Rosedale If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 1934 9. Birthplaca (State or Foreign Country)
Dec. 27, 1933 Maryland 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Days Hours Min 10 M 2 F -64-63 Yrs. 216-30-9755 Usual Residence of Dacedent 10a Stata 10b. County 10c. City. Town or Location Middle River Md Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21220 USA 347 Grovethorn Road 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 ☑ No Specify: White 3 ☑ Widowad 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondary (0-12) Collaga (1-4or 5+) Truck Driver Trucking 8th 18. Mothar's Neme (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Mary C. Bowers Edward B. Surguy 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Coda)
2408 Copper Ave. Baltimore Md. 21219 19a. Informant's Name/Ralationship (Type, Print) Gary Surguy / son 20b. Placa of Disposition (Nama of cemetary, cramatory or othar placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata ♦ Burial 2 Cramation 3 Ramoval from Stata 3/5/98 Hill Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Holly Baltimore Md. 22. Nama and Addrass of Facility 21. Signature of Funeral Sarvice Licansas Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 23a. Part1. Enter the disease, or complications that caused the death. Up not anter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Immediata Causa (Final disaasa or condition resulting in deeth) Subarachnoid Hemorrhage Dua to (or as a consequance of) Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in deeth) Lest Dua to (or as a consequence of): Dua to (or as a consaquanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Wara autopsy findings available prior to 24a. Was an autopsy complation of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to madical axaminar? 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury et Work? 28d. Dascribe how Injury occurred 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 3 Suicida 6 Could not be 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At homa, farm, straat, factory, offica building, etc. (Spacify) 4 Homicide

29a. Certifian

2

Certification:

edicai

Director: /

hin 24 hours eff the Funerei Di mpletely filled in

To the To the Complet

12 Certifying Physicien: To the best of my knowladga, daath occurred at tha tima, data and placa, and dua to the cause(s) and mannar as steted.
2 Redical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and mannar statad.

29b. Signatura and titla bl cartition

29c. Licansa number

29d. Data signed (Month, Day, Year)

3. Time of Death

10d. Insida City Limits

Approximete Intarvel Batween Onsat end Death

18 hours

1 ☐ Yas 2 ☑ No

12:57 PM

D28717

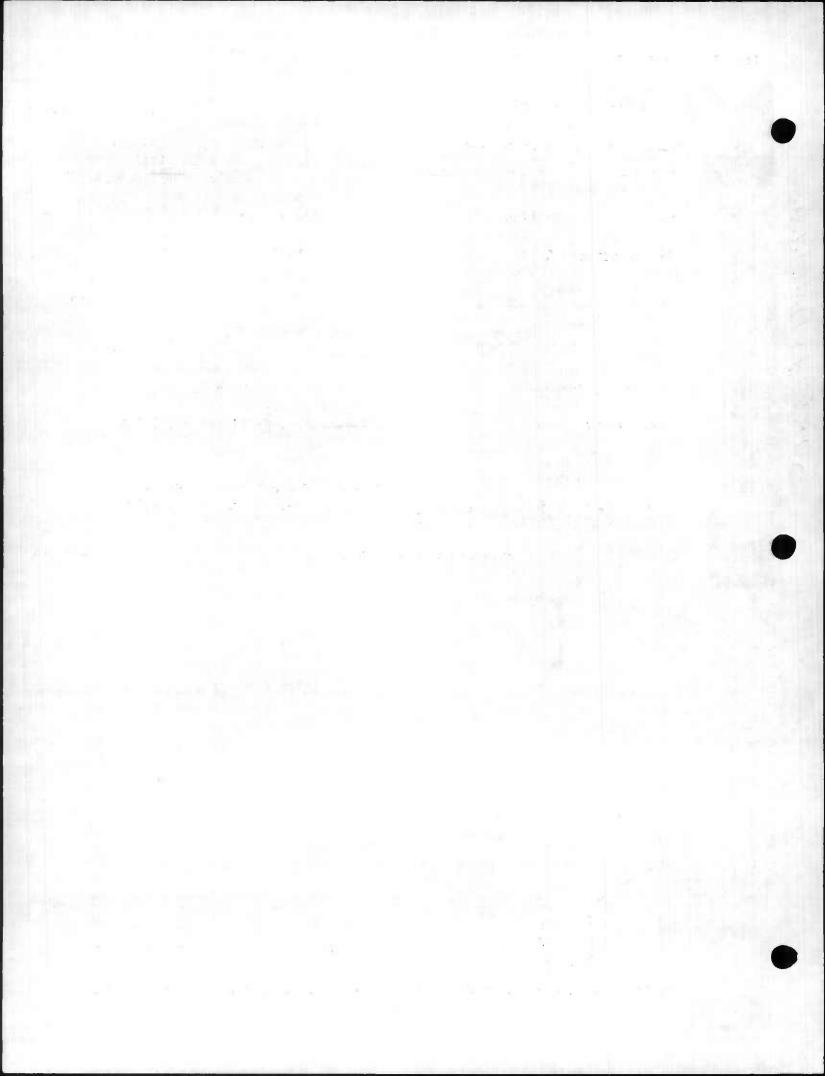
March 2, 1998

30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

DR Stephen Selinger MD 9000 Franklin Square Drive Baltimore Maryland 21237

31. Data filad (Month, Day, Yaar) State Registrar MAR 06

32. Ragistrar's Signatura

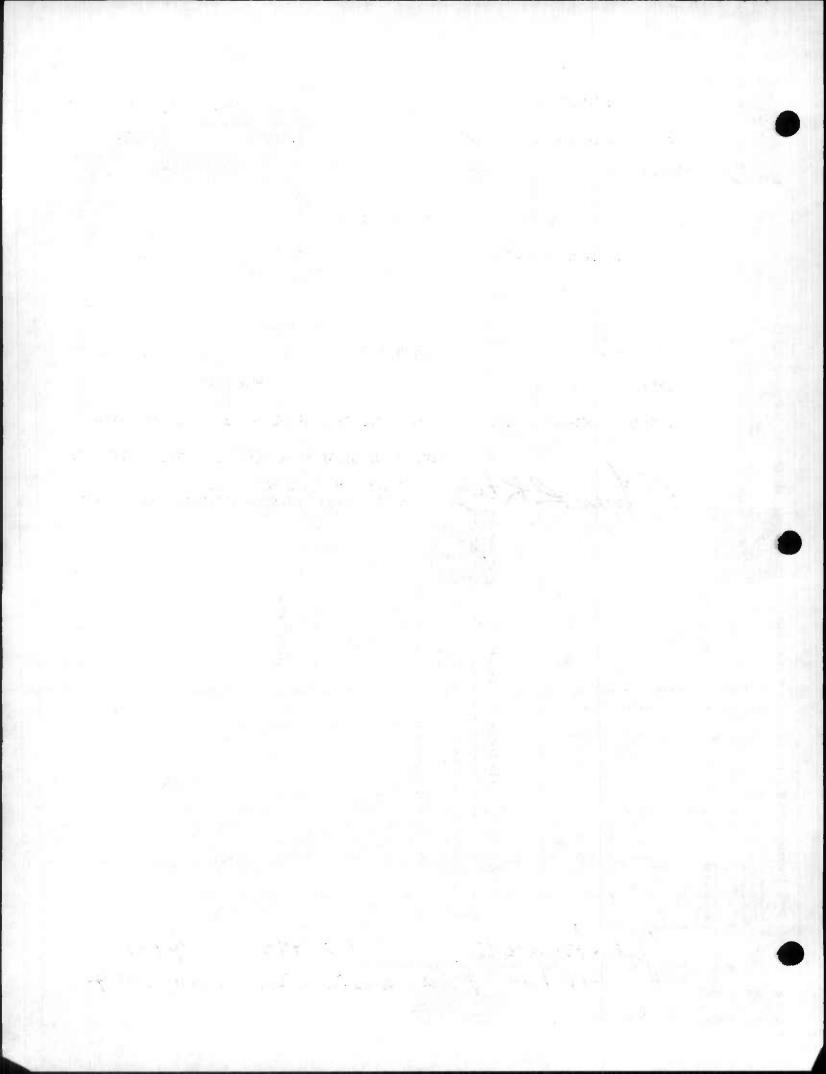


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 07163

2011						Ce	rtificate o	f Death	,	Reg. No.) (1103
Physic		1. Decedent's Neme (First, A LYDA J. SUM							2. Dete of De Month MARCH		Year 1998	3. Time of Deeth 12:50 A.M.
/Medi Exami		4e. Fecility Neme (If not institute WESTMINSTER			Н		4b. City, Town, WESTMIN	or Location of Deet	Location of Deeth 4c. County			
Funeral Director		5. Sociel Security Number 216-34-6905		4 DIA ONE	Nge (In yrs. 76	lest birthdey) Yrs.	If Under 1 Ye Months De		in (Month. De	th by, Year) , 1921	9. Birthp Cour W •	place (State or Foreign htty) VIRGINIA
wo m		Usual Residence of Deceder 10a. Stete 10b. Co			10c. City	y, Town or Lo	ocation				1	IOd. Inside City Limits
the Merylen 28a-f show	ctor	MD BA	LTIM	IORE		E	SALTIMOR	E				1 ☐ Yes 2 🛣 No
€ 8	Director	10e. Street end Number					10f. Zip Code	Э		10g. Citizen of		
s 23a	srai	2840 TENNES	SEE					2122			.S.A.	
or ite	by Funeral	11. Merital Status 1 □ Never Married 2 □ 33 □ Widowed 4 □ Divo	12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Deles:			Was Decedent of If Yes, specify C 1 ☐ Yes 2 ☑ N		(Specify Yes or No erto Rican, etc.)	Special	ick, White,	e - Americen Indien, ck, White, etc.	
	eted	15. Dece (Specify only hi	ducation ade completed)	16e. Dece	Decedent's Usuel Occupetion (Give kind of work done during most of worki life. DO NOT use retired)			16b. Kind of B	susiness/Industry			
withir jene. r than	Completed	Elementery/Secondery (0-12) College (1-4or 5+) 12TH GRADE Hi				HOMEN					IOMEMA	KING
should be filed nd Mental Hygi marked other imatic event, i	Be	17. Fether's Neme (First, Mid FRENCH ISOM	•				Į.	leme (First, Middle FLANIGAN		ne)		
s 1 and 2 should be filed f Heelth and Mentai Hyg fem 27 is marked othe other traumatic event,	P	19a. Informent's Name/Relat				19b. Meilii	na Address (Stre		Rurel Route Numb		State 7in	Codel
1 end 2 : Heelth ar em 27 is other trau		RICHARD SUM			1)				E - FERNI			
permit. Peges 1 enc Department of Heelt Important: If item 27 any Injury or other once.		20e. Method of Disposition 1 □ Burial 2 □ Cremeti 4 □ Donetion 5 ☑ Othe			e C	em etery, cres	sition (Name of metory or other p MEMORI	olece) AL PARK	Date 3/4/98	20c. Location SYKESV		
Departr Departr Importa any Inju		21. Signaland of Fugural Sen	ice Lice	riseen 1/1		22	2. Name end Add	dress of Fecility	OME INC			
20 = 20		* feces	کے	KKU	-7	and .			UE-BALTIN	MORE, MI	21	1229
Physician /Medical Examiner		23a. Part1. Enjoy the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in deeth)	List only	e. CV.	A			ying, such es cerd	ac or respiretory e	rrest,		Approximete Intervel Between Onset end Deeth
ש פ	iner			AS	CV	r es e consec	quence ot):					15000
death certificete be executed e ettending physician end ed for use es the bunel-transit	Examiner	Sequentially list conditions,	ſ	Due to (or es e consequence of):								000
sician		Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	1	c. N	em	nly	_				7 m	
ng phys	Medical	resulting In deeth) Lest	1	11		. 4	equence of):					2
eam cen ettendin for use			d. /	y pu	Hry	mide	sin			Dy		
the ett	Physician/	Pert II. Other significant cond	ditions o	ontributing to death	but not resu	ilting In the u	nderlying ceuse	given in Pert I.	23b. Dld	tobacco use co	ntributa to	the cause of death?
es met me de igned by the be deteched	by								- 10	Y•• 2□ € 0	3 □ Prot	bably 4 Unknown
e law requires thet the hes been signed by th ge 2 should be detech	Completed								24e. Wes perfo	en eutopsy rmed?	COI	ere autopsy findings eileble prior to mpletion of cause deeth?
E as a									10	res 2 No	10	☐Yes 2☐ No
Physician: In this certificate rai director, per	Be	25. Wes cese referred to med exeminer?	licel	Hospitel:				Whor:	eeth (Check only o			
	7: To	1 Yes 2 No 27. Menner of Deeth		1 ☐ Inpet 28e. Dete of Inj (Month, D		ER/Outpatien 28b. Time of	I SLI DOA	4 IZNOUISING	Home 5 Resident			0
Attending in death.	ation	1 Neturel 5 Per investigation		ey Year)	Injury	28c. In W	?ork? □ Yes 2 □ No		28d. Describe how injury occurred			
Properties of the part of the	Certification:	3 ☐ Suicide 6 ☐ Co	uld not b ermined	28e. Place of in	ijury - At ho tc. (Specify	me, farm, str	arm, street, factory, office 28f. Location (Street end Number or Rural Route City or Town, Stete)					/ Route Number,
2	edicai	29a. Certifier 1 Certi (Check only one) 1 Medic	lying Ph	ysician; To the best ntner: On the basis of end menner s	of examineti	vledge, deeth ion end/or inv	occurred et the restigetion, in my	time, dete end pia opinion, deeth oc	ce, end due to the curred et the time,	cause(s) and modate end piece,	enner as st and due to	ated. the cause(s)
Torn	2	29b. Signature and title of cert	m	whilet	-		29c. Lice	nse number	3	29d. Date signe	d (Month, I	Dey, Year)
35-		30. Name and address of pers	on who	completed ceuse of	deeth (it) m	23e) (Type,	Print)	1		1		-
		31. Dete filed (Month, Dey, Yeer) & 32 Registrar's Signeture									115-	+
Sta	te	MAD OC 1000	01/	Luly Maria	al S Signer	1.00						

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** FREDERICK S. SMALL 25 FEB. /Medical 1998 6:15 PM 4a. Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOMEWOOD NURSING HOME WILLIAMSPORT
If Under 24 Hrs. 8. De WASHINGTON If Under 1 Year Months Days 5. Social Security Number 7. Age (In vrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1♥M 2□F Yrs. Director 234-01-7631 95 AUG. 7, 1902 Usual Residence of Decedent 10e. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Madical Examiner must be notified at 1 Ves 2 No Director WV BERKELEY MARTINSBURG 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 105 OLD MILL RD. 14. Rece - American Indian, Funeral 25401 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Black. White, etc. Armed Forces 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7 Department of Heelth and Mental Hygiene. Important: If Item 27 Is marked other than "n any Injury or other treumatic avant Elementary/Secondary (0-12) College (1-4or 5+) 12 CONTRACTOR RESIDENTIAL BUILDER 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 HOMER C. SMALL ELLA SILER 19a. informant's Name/Relationship (Type, Print) 19b. Malling Address (Straet and Number or Rural Route Number, City or Town, State, Zip Code) 105 OLD MILL RD., MARTINSBURG, WV 25401
Date 20c. Location - City or Town, Stete NORMA S. HOLLIDA/DAUGHTER 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE CEMETERY 2/28/98 MARTINSBURG, WV 21. Signetuj of Funeral Service Licansee BROWN FUNERAL HOME, PO BOX 821 327 W. KING ST., MARTINSBURG, WV 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner physician end s the buriei-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or es a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ederich Sm Division of Vital Records, by 24e. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 🗆 Yes 1 ☐ Yes 2 ☐ No voke 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 - Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Medical Examiner: On the basts of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier Medical 29c. License number 26806 ine and address of person who completed cause of death (Item 23a) (Type, Print)

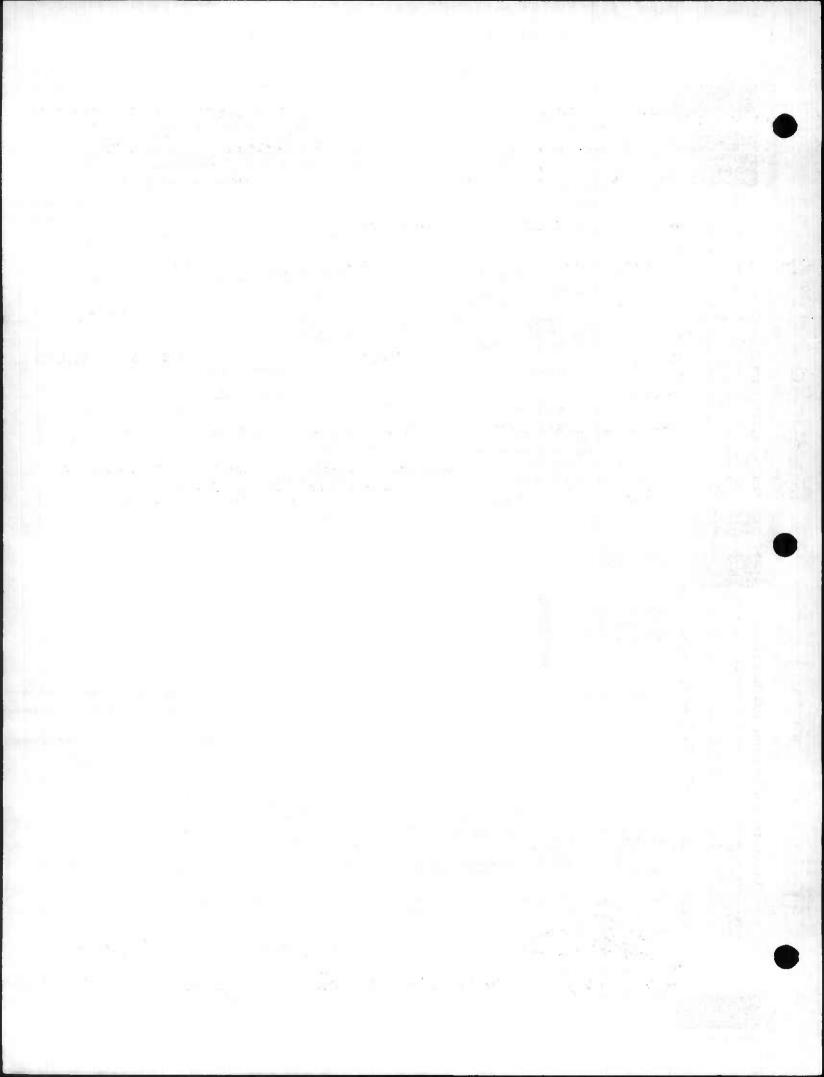
State Registrar tate filed (Month, Day, Year)

1998

MAR 05

32. Registrar's Signature

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene STEVEN Certificate of Death STERNBERGItems: 23a part I, 27, 28a-f per MEO G-757 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** STEVEN В. STERNBERG FEBRUARY 27, 1998
cation of Death 4c. County of Death 3:53A.M. /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) **Examiner** SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 20 F Months Days Hours Min Yrs. Sept. 9, 39 1958 Washington, DC Director 212-76-0247 Usuat Residence of Decedent with the Marylend worle 10a State 10h. Counts 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar must be incitined as 1 XYes 2 No Directo Maryland Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9620 East Light Drive 20903 U.S.A. death Funeral 14. Race - American Indian, 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. nit. Pages 1 end 2 should be filed within 72 hours after cartmant of Health and Mental hygiena. ortant: If item 27 Ia marked other than "natural", or iter linjury or other traumalic event, "a Medical Examination of the present of t 1 Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: p 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cotlege (1-4or 5+) Elementary/Secondery (0-12) 2 Years Administrative Clerk U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlotte Greenberg Hyman M. Sternberg P 19b. Malting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8601 Raleigh Avenue, Annandale, Virginia 22003 Henry Sternberg, Brother altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3/02/1998 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: If any Injury or Mount Lebanon Cemetery Adelphi, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, NW, WASHINGTON, DC 20012 23a. Pert1. Enter the disease, or complications that caused the wath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medicai Immediate Cause (Finat DRUG INTOXICATION (ANTIHISTAMINE) disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner certificate be axecuted physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of). Box 68760 Physician/Medical Due to (or as a consequence of): 88 950 Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? O 1 Yes 2 No 3 Probably 4 Unknown signed I à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen pege 2 has 17 Yes 2 No LRIYES 2 No certificete director, 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 XER/Outpatient 3 DOA this uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of Certification: 28c. tnjury at Work? A 1 Naturel 5 Pending 1 Yes 2 No investigation 2 TAccident 2/27/98 subject ingested drug

Attending Physician: death.

Director 6 hours

Division of Vital Records.

2 State Registrar

Medicai

3 Suicide 4 Homlcide

29b. Signature and title of certifier

MAR 05 1998

29a. Certifier (Check only one)

Radentz 5, Stephen MP 31. Date filed (Month, Day, Year)

6 Could not be

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32 Registrar's Signature

28e. Pleca of Injury - At home, farm, street, factory, office bullding, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Common Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

**Common Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

O.C.M.E.

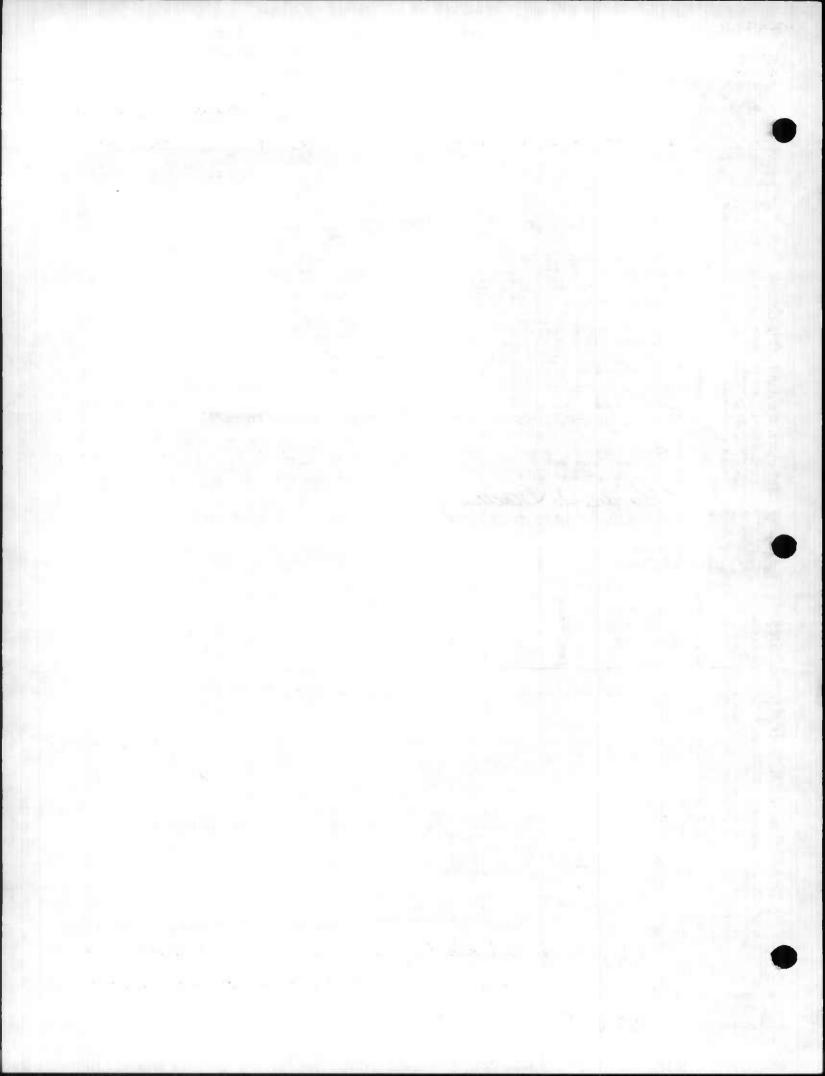
111 Penn Street, Baltimore, Maryland 21201

Gaithersburg, Md.

28t. Location (Street and Number or Rural Route Number, City or Town, State) 303 Westside,

29d. Date signed (Month, Dav. Year)

FEBRUARY 27,1998

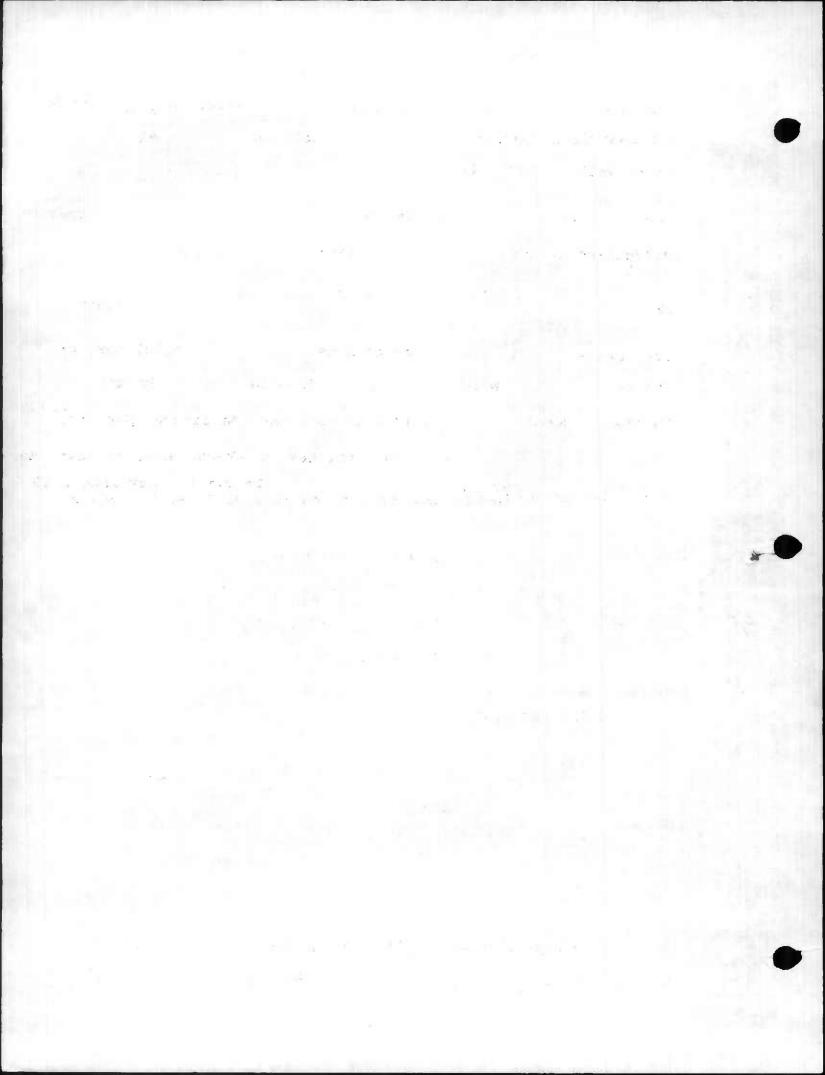


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth Month **Physician** 3:30pm 03, 98 Willie Mae Thomas · /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, giva street and number) 4c. County of Death Examiner Good Samaritan Hospital Baltimore Birthplece (State or Foreign Country)
 SC 5. Sociel Security Number 6 Sax 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Dev. Year) **Funeral** 1 M 2 XF Months Days Hours 53 248-86-7631 Yrs. Director 12-21-44 Usuel Residence of Decedent the Merylend 10e Stete 10b County 10c. City. Town or Location 10d. Insida City Limits 7 ie merked other than "naturel", or items 23a or 28a-f ehow treumstic event, tre Modical Examèrer must be notilised at MD NA Baltimore tX as 2 No Director 10e. Street and Number 10f. Zio Code 10g. Citizan of Whet Country? 21205 USA 1017Rutland Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Rece - American Indian. Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Heelth and Mentel Hygiene. Important: If item 27 ie marked other than "naturel", or item any injury or other treumatic event, the Medical Examples. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Merried Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: 3☐Widowed 4☐Divorced þ Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Health Aide Social Service 12th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Meiden Sumeme) Be Buckson Estelle George Ward 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 21205 19e. Informent's Neme/Reletionship (Type, Print) 1017 Rutland Avenue Baltimore, Maryland Sherry Ward 20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Suriel 2 Cremetion 3 Removel from State King Mem. Pk. Cem. 03-09-98 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22. Name and Addrass of Fecility Baltimore, Maryland 21202 ale lan WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Medical Immediate Cause (Final BRAIN disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Ceuse (Diseesa or injury thet Initieted events resulting in deeth) Last Box 68760 Physician/Medical Pert II. Other significant conditions contributing to deeth but not resulting in the undertying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 ⊞Wiknown 1 ☐ Yes 2 ☐ No 14112ev Know þ 24b. Were eutopsy tindings eveilable prior to completion of cause of death? 24e. Wes en eutopsy Completed 1 Yes 2 No 1 Yes 2 □NO certificate 25. Wes case reterred to medical examiner? Be 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No this funeral c 27. Menner of Deeth 28e. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending 1 Waturel or Attending after death. Director: After Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homlcide 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi edical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the ceusa(s) and menner stated. 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifian 29c. License number MD 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 821 N. EUTAN ST Soute JOS HAPIAMI MD 32. Regis ars Signature 31. Dete tiled (Month, Day, Yeer) MAR 0 6 1998 who Davidson-Randell

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day Month **Physician** 1 1998 March 11:45pm Meta Thomas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner 5700 Johnnycake Road Baltimore Baltimore If Under 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Sacurity Number 7. Age (In vrs. last birthday) Birthpiace (Stata or Foraign Country) **Funeral** 1 M 20 F Months Yrs. 74 Nov 15, 1923 Director 218-16-1866 Mary land Usuei Rasidence of Decedant the Maryland 10a State 10h Count 10c. City. Town or Location 10d. Insida City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified as 1 ☐ Yas 2 No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than 'natural', or itema 29a and Injury or other traumatic event, tra Medical 5700 Johnnycake Road 21207 United States Funeral 14. Raca - Americen Indian, Black, Whita, atc. 12. Was Dacedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas: 1 Never Married 2 M Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Eiamentary/Secondary (0-12) Coliaga (1-4or 5+) Telephone Operator Telecommunications 18. Mothar's Nama (First, Middle, Melden Sumema) 17. Fathar's Nama (First, Middla, Last) Frederick Dimpert Elizabeth Stein 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Deborah Thomas/Daughter 5700 Johnnycake Road Baltimore, Maryland 21207 20b. Place of Disposition (Nama of cematery, cramatory or other place) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1⊠ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 Donation 5 Othar (Spacify) Meadowridge Cemetery 3-5-98 Elkridge, Maryland 22. Nama and Addrass of Facility
Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funaral Service Licenses Show a. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Entar the disease, or complications that ceused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Batween Onsat end Deeth **Physician** /Medicai Immediata Causa (Final disaase or condition rasulting in death) Myelodysplastic Syndrome Examiner Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequantially list conditions, if any, leading to immadiata ceuse. Enter Underlying Causa (Disaasa or Injury that initieted events rasulting In daath) Last Due to (or es e consequence of) Box 68760 Physician/Medical Dua to (or as a consaquance of): 88 attending 23b. Did tobacco use contribute to the cause of death? Part II. Other algoriticant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to 24a. Was an autopsy periormed? Completed peen s complation of causa of deeth? has 1 Yes 2X No 1 ☐ Yas 2 ☐ No certificata or Attending Physician: 25. Was cesa rafarrad to madical axaminar? Be 26. Placa of Death (Chack only ona) Other: 4 ☐ Nursing Home 5 🖾 Rasidance 6 ☐ Othar (Specify) P 1 TYas 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this funeral 27. Mannar of Daath 28a. Deta of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 WNetural 5 Panding To the hours after within 24 hours after the To the Funeral Director. After an in the factor of the 1 Yas 2 No death. invastigation 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 29e. Certifiar 1 🕱 Cartifying Physician: To tha best of my knowledge, death occurrad at the tima, data and place, and dua to tha cause(s) and menner es steted. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated. 29b. Signatura end titla of certifian 29c. Licanse number 29d. Data signed (Month, Day, Year)

18

Registrar

31. Data fiiad (Month, Day, Yaar)

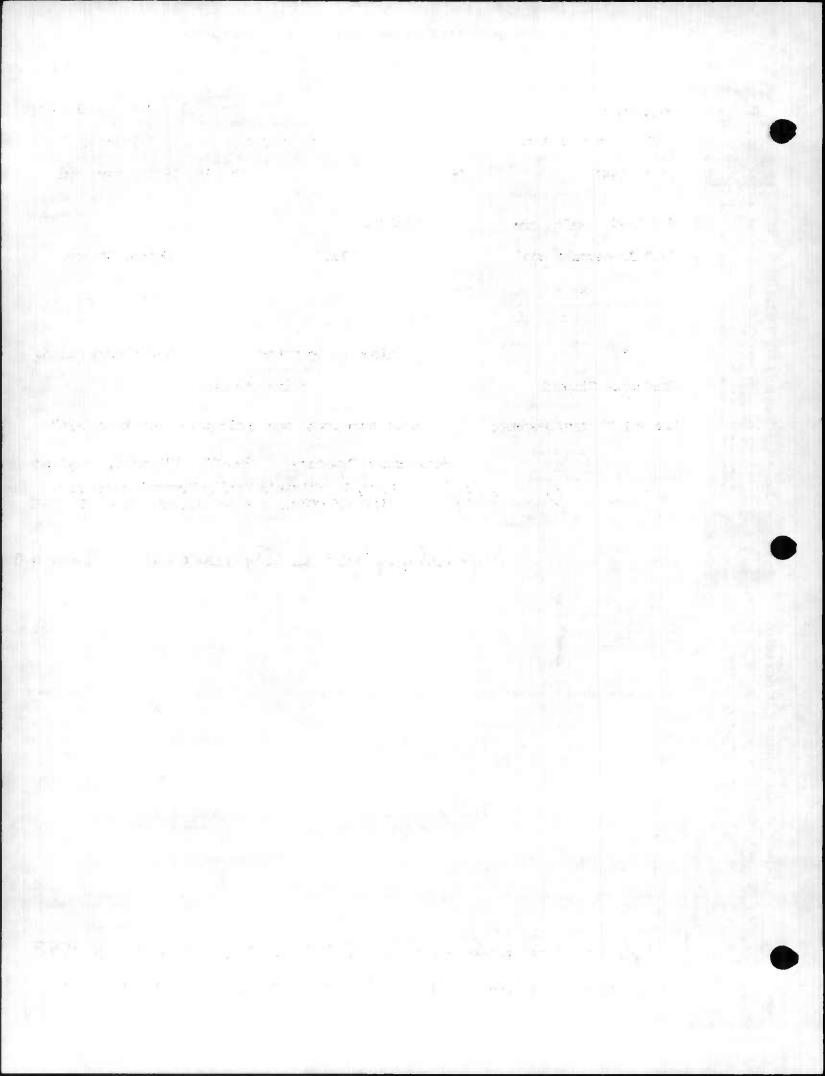
MAR 06

1998

Brahmer, MD 32. Registrar's Signatura 20

Johnstopkins

30. Nama and addrass of person who complated causa of daeth (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Items: 4a, 28f per MEO G-757 3/17/98 dh 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Month Day **Physician** 1230 Ronald Todd Tanner February 27, 1998 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner Route 40 and Stevenson Lane Rd. Baltimore County Baltimore If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1**X** M 2 □ F Yrs. Director 25 216-13-7788 April 13, 1972 Towson, Maryland Usuel Rasidance of Dacedant 10a. Steta 10h County 10c. City, Town or Location 10d. Insida City Limits 28a-f show risust be notified at 1 ☐ Yas 2 ☐ No Director Baltimore Maryland Perry Hall 10e. Street and Numbar 10f. Zip Code 10g. Citizan of What Country? ò items 23a 4226 Chapel Road 21128 LISA death Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2XXNo If Yas, Giva Yaar or Datas: 11. Merital Status Was Decedant of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. permit. Peges 1 end 2 should be filed within 72 hours after of Depertment of Heelth and Mental Hygiane. Important: if Item 27 Is merked other than "natural", or flet many injury or other traumatic event, the Mexical Examples ones. the Medical Examiner Bleck, White, etc. 1 Navar Marriad 2 Marriad 1 ☐ Yas 2 No Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Spacify only highest grada completed) Elementary/Secondery (0-12) College (1-4or 5+) N/A Electricians Helper A & J Electric Co. 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Ronald B. Tanner Louise D. Laudenklos 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Ronald B. Tanner (Father) 4226 Chapel Road Perry Hall, Maryland 21128 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition 1 KNBurial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) St. Joseph's Church Cem. March 3, 1998 Baltimore, Maryland 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility E.F. Lassahn Funeral Home, P.A. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such es cerdiac or respiratory arrast, shock, or haart failure. List only one cause on each line. 11750 Belair Road Kingsville, Md. 21087-1351 Approximata Intarval Batween Onset and Death Physician /Medical Immediata Causa (Finel disaasa or condition resulting in death) **Examiner** Sequentially list conditions, if eny, laading to immadiate ceuse. Enter Underlying Causa (Disaase or injury that initieled evants rasulting in daath) Lest and Dua to (or as e consequence of): Physician/Medical Dua to (or as a consequence of): 88 Part II. Other algorificent conditions contributing to death but not rasulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of deeth? 2 No 3 Probably 4 Unknown signed t by 24b. Wara autopsy findings available prior to completion of causa of daath? Completed 24a. Was an autopsy paga 2 si 1 Yas 2 No certificate Be 25. Was cese rafarred to medical 26. Pleca of Daath (Check only ona) Othar: 4 Nursing Home 5 Residence Nother (Specify) ROA) Hospital: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 1 Yes 2 No this 28d. Describe how injury occurred 27. Menner of Daath 28a. Date of Injury (Month, Day Yaa 28b. Time of 28c. Injury at Work?

tha daath certificete be axecuted Box 68760 P.O. Records, Viital Attending Physician: Certification: To ision of funeral Aftar death. Medical

altimore, Maryland 21215-0020

22.30 PM 5 Panding Investigation 1 Natural F23 27 1998 28f. Location (Street and Number or Rural Route Number, City or Town State) Stevens er in automob 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 ☐ Homicida ROADWAY Rd.,

29a. Certifian one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and piece, and due to the ceuse(s) end membra as stated.

Medical Examinar: On the basis of axamination end/or invastigation, in my opinion, death occurred et the time, date end place, and due to the ceusa(s) and mannar stated.

29b. Signatura end titla of certifier

29d. Data signed (Month, Day, Year) 29c. License number

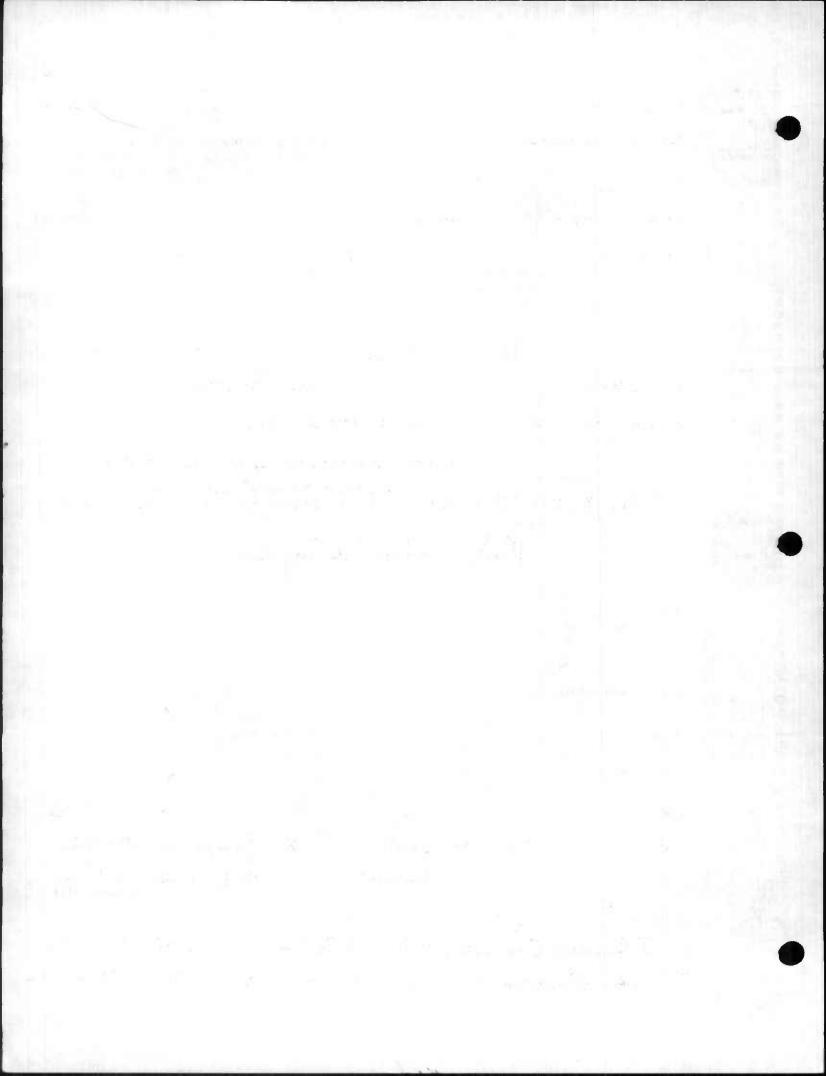
Observan

30. Nama and addrass of person who complated ceusa of death (Item 23e) (Type, Print) O JANOUAN, M.D. 2112

MD DUNDALL AVE. 21222

State Registrar

31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura who Davidson Randall MAR 05 1998



Item: 20b Per FH Film G-758 4-9-98RC Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Items: 19a, b, 21, 22 per F.H. G-758 4/8/98 rep Certificate of Death Items: 20b-c per FH G-757 3/27/98 dh 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month Physician Edwin February 19, 1998 4:15 PM 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Baltimore Franklin Square Hospital Center Rosedale If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Sept. 01, If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□ F Deys 80 Yrs 1917 unknown Director 104-05-0724 Usual Residence of Deceden the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "naturel", or flems 23a or 28a-f show other treumstic event, the Worldal Examiner must be notified at 1 ☐ Yes 2X No Baltimore County Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 21237 2000 Adel Avenue filed within 72 hours after death Hygiene. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? UNKNOWN 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11 Maritel Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nal any injury or other treumatic event, the Medica page. Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unknown unknown 19a Informant's Name/Relationship (Type, Print) Mrs. [erry Summerhill [Friend] 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) unknown 2000 Odell Ave. Baltimore, Md. 21237 unknown 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-9-98 4□Donetion 5뮻Other (Specify) in state | Garrison Forest Va. Cem. 3/31/98 Owings Mills Md. 21. Signeture of Tyneral Service Licensee Joseph L. Russ Rohald S. Wade, Directo per vr 22 Name and Address of Facility Board, 655 W. Baltimore Street Baltimore, Maryland 2120 oseph L. Russ Funeral Home 2120 W. North Ave. 21216 23e. Partl. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) 1 month Pneumonia Examiner Due to (or as e consequence of) Examine Metastatic Colon Carcinoma attending physician and for use es the bunel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or es e consequenca of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? P.O. the i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed by Chronic Obstructive Pulmonary Disease à 24e. Was en eutopsy performed? 24b. Were autopsy findings available prior to Completed peen Severe Anemia completion of cause of death? hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this certificete Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 inpatient 2 □ ER/Outpatient 3 □ DOA funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: After t 5 Pending investigation Hospital or Attending 1 Netural s efter death.
I Director: Aft
ad in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide within 24 hours of To the Funeral C 150 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es stated.

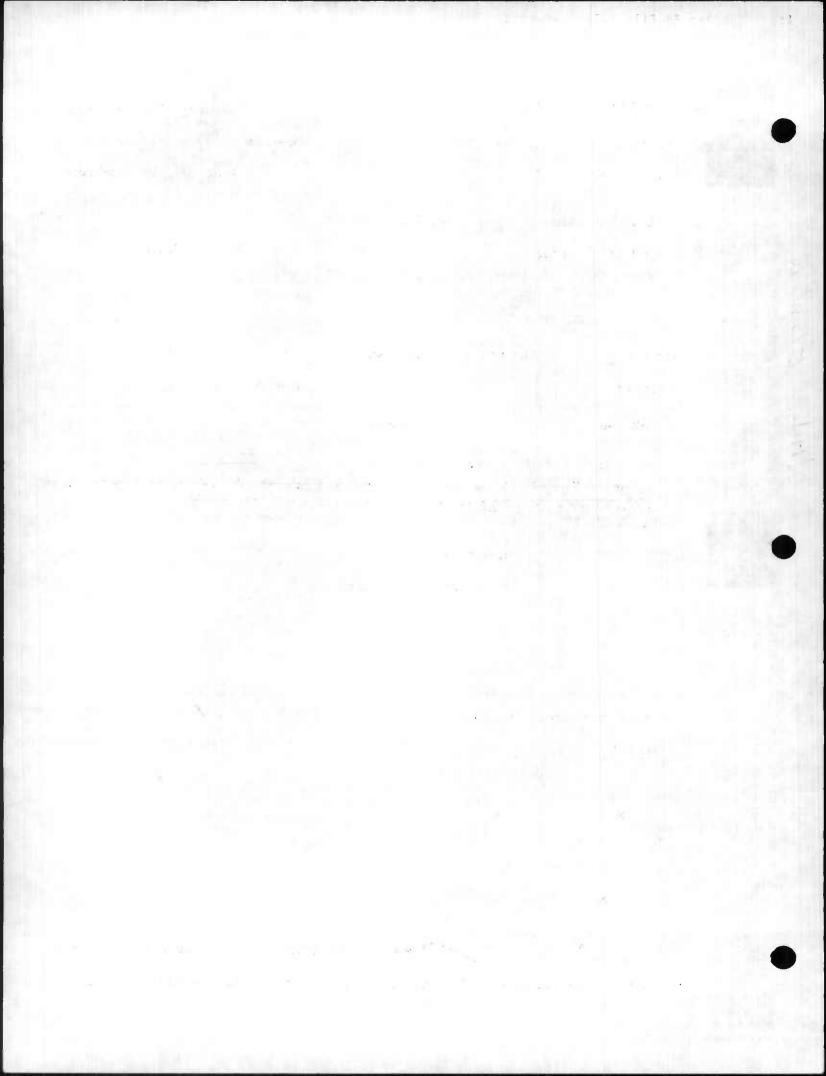
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end plece, end due to the ceuse(s) and manner stated. edical 29a. Certifie completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 19, 1998 RD 2335 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) DR Anthony Samphilipo MD 9000 Franklin Square Drive Baltimore Maryland 21237 31. Dete filed (Month, Pay Year) MAR 0 6

32. Registra Signature .

1998

he Davidson Randale

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) Rita Teresa Wheelbarger 2. Dete of Deeth 3. Tima of Death Month March 1, 1998 9:00 am 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Center Baltimore Rosedale 8. Dete of Birth (Month, Dey, Year) Feb. 26, 1923 7. Age (In yrs. lest birthdey) If Under 1 Yaar | If Under 24 Hrs. Birthplece (Stete or Foreign Country) 6. Sax Hours Months Deys 215-18-6635 75 Maryland Usuei Residence of Decedent 10d. Inside City Limits 10e Stata 10b. County 10c. City. Town or Location Maryland Baltimore Essex 1 Tyes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 727 Essex Avenue 21221 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Datas: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien, 11 Merital Status Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Housewife Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Maryann Czyzechowicz Martin Golabieski 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Roland J. Wheelbarger (SON) 6503 Upland Road Fork, Md. 21051 20b. Pleca of Disposition (Neme of 20a. Method of Disposition Dete 20c Location - City or Town, State Bel Air Mem. Gardens 1 XBurial 2 ☐ Cremation 3 ☐ Removel from State 3/4/1998 Bel Air, Md. 4 Donetion 5 Other (Specify) 21. Signature of Feneral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 23a. Part 1. Enter the disease, or complications that crased the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Death Immediate Cause (Final diseese or condition resulting In death) Congestive Heart Failure Due to (or es a consequence of) Arterioslerotic Cardiovascular Disease Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequenca of) Due to (or es a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 450 Unknown Left Metastatic Breast Cancer 24b. Were eutopsy lindings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 MInpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel

physician and s the burial-transit that the death certificate be executed Physician/Medical USB as P.O. signed t 2 Completed has To the Hospital or Attending Physician: The within Ext. brows after death.

To the Eureral Director: After this cardifference completes within the completes and the completes certificate of Vital Be 2 Certification:

Physician

Examiner

Funeral

Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be

If them 27 is

Physician

/Medical

Examiner

wheel barder

/Medical

Director

Funeral

PV

25. Wes case referred to medical exeminer?

1 Yes 2 No 27. Menner of Deeth

3 Suicide

29a. Certifier

4 | Homicide

5 Pending investigation 6 Could not be

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

32. Registra's Signature

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) and menner es steled.

2 Medical Examiner: On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s)

29b. Signeture end title of certifier

29c. Licanse number

D45475

29d. Data signed (Month, Day, Year)

March 1, 1998

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

9000 Franklin Square Dr. Mohammad, Rahnama M.D. Baltimore MD. 31. Dete filed (Month, Pay, Year)

State Registra

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	Decedent's Nama (First, Middla, Last)										2. Deta of De			3. Time of Death	
	Physiciar · /Medica	_	Verna Christin	e Wi	lson								Month Februa	ry 28,	1998	10:09 pm	
	Examine	r f	la Facility Nama (If not instituti			ocation of Deeth 4c. County of Death											
		-	Johns Hopkins						If Undar	1	Balti If Undar				I/A	(0)	
	Funeral Director		5. Social Security Number 245 07 1076	6. Sax]м 2 <mark>∏</mark> } F	7. Aga (II	n yrs. Ia	st birthdey) Yrs.	Months	Deys	Hours	Min.	8. Deta of Bir (Month, De			ca (Stata or Foraign	
Ш			Usual Rasidance of Dacedant								1		Dec. 2	5, 1915	South	Carolina	
	how		10a. Stata 10b. Count	•		10	c. City,	Town or Lo							100	I. Insida City Limits 1 ☐ Yas 2 🛣 No	
	Sa-f	2	Maryland Balti	more				Middl	_								
	23a or 2	5	10e. Street and Number 27 A Oak Grove					10f. Zip	2122	0			10g. Citizen of What Country? U.S.A.				
020	LIS O'.	2	11. Marital Status 1 Navar Married 2 Ma 3 XWidowed 4 Divorce	rried	12. Was Dec Armed Fo 1 ☐ Yes If Yas, G Year or D	orcas? 2⊠No iva	r in U,S		Was Deced If Yes, spec 1 ☐ Yes	2	lispanic Or an, Maxica Specify:		ecify Yes or No Rican, atc.)	14. Ra Bia Specif	ce - Amaricen ick, Whita, at fy: Whit	c.	
5-0	72 ho	200	15. Deceda (Specify only high					16a. Dece	dant's Usua kind of wo	l Occup	etion during mos	st of work	ing	16b. Kind of 8	Businass/Indu	stry	
2121	d within giene.	De Completed	Elemantary/Sacondary (0-12)		Coilaga (1-4or 5+)			(Giva kind of work dona during most of work life. DO NOT use retired) Office Manager						Iron &	ron & Metals		
Maryland 21215-0020	12 should be file nand Mentel Hy, I'm marked othe reumatic event,	o De C	17. Fathar's Nama <i>(First, Middle</i> Felix George	a, Last)									spratt	, Maidan Sumar	ma)		
, Mar	and 2 sho saith and 1 27 is me or treum		19a. Informant's Name/Ralation Eldon B. Wilso			on)		19b. Mailing Address (Street and Number or Rur 7 A Maple Drive Middl					ural Routa Number, City or Town, State, Zip Coda) le River, Md. 21220				
Itimore,	permit. Pages 1 and 2 Department of Health is Important: If fem 27 is any injury or other tre ence.	2	20e. Method of Disposition 1XX Buriai 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (amoval from	04	cei	nce of Dispo matary, crain Air	matory or o	ther play	dens	3/	3/1998	20c. Location Bel Ai			
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service	2	a de	/		Br		nsk	i Fun	eral	Home I		1 3 212	221	
	Physician		Intervel Bat													Approximete Intervel Batween Onsat and Daath	
	/Medical Examiner		Immediata Causa (Final disaasa or condition resulting in death)	6	Chro			tructi		ılmo	nary	Dise	ase		7	lears .	
	P # 2	5	Due to (or as e consaquence of):														
o,	ficate be executed 3 physician end as the burial-transit	Exam	Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Ceusa (Diseasa or Injury	J'		Due	to (or	as a consac	quanca of):								
68760,	nificate be ng physiciar as the buri	200	Ceusa (Diseasa of Injury that initiated avents rasulting in daath) Lest		,	Due	to (or	es a consec	quence of):						i		
Box	es that tha death certificate by the ettending be detached for use a	- Jain			l												
o.	y the ached	ly al	Part II. Other significant condit				ot rasul	ting in tha u	ndarlying c	eusa giv	an In Part	l.		tobacco uae co Yes 2□ No		he cause of death?	
2	s that	, y	Severe Aortic	Regu	rgitat	tion							100	Yes 2LINO	3 Floba	ibiy 4 Olikhow	
Vital Records,	been should	חפופת											24a. Was perf	s en autopsy ormad?	avail	a autopsy findings abla prior to pletion of ceuse eath?	
ž	The law ate has pege 2	5											10	Yas 2⊠No	10	Yes 2□ No	
ta	ysicien: The la s certificate ha director, page		25. Was case refarred to madic axaminar?	-							26. Plac	a of Daat	th (Check only	ona)			
> >	Physicien: this certific ral director,	2	1 ☐ Yas 2 🖾 No	F			2□E	R/Outpatie			4LIN	ursing Ho		ldence 6 □Ot			
ion	Attending Physical Control of the Co	ation.	27. Mannar of Death 1 ☑Natural 5 ☐ Pend 2 ☐ Accidant Invas	ling tigation	28a. Date (Mor	of Injury oth, Day Ye		28b. Tima o Injury	f M	8c. Injui Wo 1 □	ryet rk? Yas 2□	No	28d. Describe	how Injury occu	rred		
Division of	5 E A E		3 ☐ Suicida 6 ☐ Coui 4 ☐ Homlcide deter	d not be mined	28e. Plec build	e of Injury ling, etc. (5	At hon Specify)	na, farm, st	reet, factor	, offica				(Street and Num wn, Stata)	ber or Rural I	Routa Number,	
	To the Hospital or within 24 hours affig To the Funeral Diff completely filled in				ner: On the b		aminatio							ceuse(s) end m deta end plece			

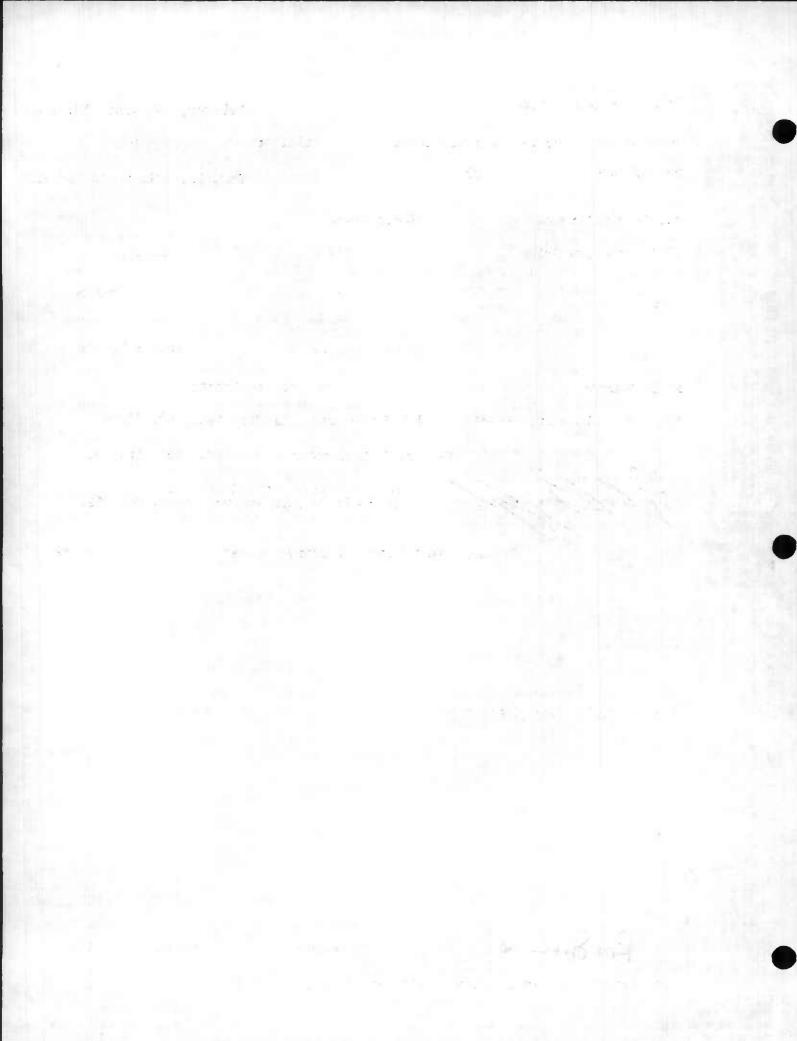
KIN Jum NO Res-000 February 28, 1998

30. Nama and addrass of person who complated causa of daath (Item 23e) (Type, Print)

Ross Summer 600 North Wolfe Street Baltimore, Md. 21287

State Registrar 31. Data filad (Month, Day, Year)

MAR 06 1998



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

Months

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2 Date of Death

Physician
/Medical
Examiner

1. Decedent's Neme (First, Middle, Last) Ronald Carl Warner

5. Social Security Number

213-34-8332

March 4b. City, Town, or Location of Death 3. Time of Death 1:45 AM

4a Facility Name (If not institution, give street and number) 7002 Oliver Beach Road

Middle River

4c. County of Deeth Baltimore

Funeral Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours aftar death v Department of Health end Mental Hydiena. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, Ita Medical Examiner manages.

Physician

/Medical **Examiner**

physician end the burial-trensit

USB BS ettending p

by the e

should b

page 2 has

director,

certificate Physician:

this is

24 hours

To the Hosp within 24 ho To the Fune completaly fi

2

The law requires that the death certificete be axecuted

Box 68760.

P.O.

Mision of Vital Records,

Examiner

Physician/Medical

2

Completed

Be

10

Certification:

edical

Maryland 21215-0020

Baltimore,

Directo

Funeral

by

Completed

with the Marylend

Usual Residence of Decedent Maryland

10b. Count

10c. City, Town or Location

Yrs.

7. Age (In yrs. last birthdey)

59

| If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | Sept. | 21, 1938

9. Birthplace (State or Foreign Ohio

10d. Inside City Limits

Baltimore

Middle River

1 ☐ Yes 2 X No

Day

10e. Street and Number

7002 Oliver Beach Road

1 M 2□F

21220

10f. Zip Code

10g. Citizen of What Country? U.S.A.

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Detes:

Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Raca - American Indien, Bleck, White, etc. White

15. Decedent's Education (Specify only highest grede completed)

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 Yes 2 No Specify:

16b. Kind of Business/Industry

Elementery/Secondery (0-12)

Stage Hand

Entertainment

17. Father's Name (First, Middle, Last)

Jesse Watkins

Harry Ison Warner

19a. Informant's Name/Reletionship (Type, Print) Phyllis A. Warner

19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 7002 Oliver Beach Road Middle River, Md. 21220

3/7/1998

20a. Method of Disposition

1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place) **Greenmount Crematory** 20c. Location - City or Town, State

Bruzdzinski Funeral Home P.A.

18. Mother's Name (First, Middle, Meiden Sumeme)

Baltimore, Md.

1407 Old Eastern Avenue Essex, Md. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line.

Immediate Ceuse (Final disease or condition resulting in deeth)

Metastatic Prostate Cancer

Approximate Interval Between Onset end Deeth 3 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as e consequence of):

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes No 3 Probably 4 Unknown

24b. Were eutopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No

25. Wes case referred to medical 1 Yes 2 No

27. Menner of Deeth

1 X Natural

2 Accident

3 Suicide

4 Homicide

Hospitel: 28a. Date of Injury (Month, Dey Year) 5 Pending Investigetion

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 Tyes 2 No

Other: 4 ☐ Nursing Home 5 ₺ Residenca 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifie (Check only one)

🖎 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Yeer)

D28768 3/5/1998

26. Piece of Deeth (Check only one)

30. Name and address of person who completed cause of de (Item 23a) (Type, Print)

Mario A. Eisenberger M.D. 600 N. Wolfe Street Baltimore, Md. 21287

Registrar

31. Date filed (Month, Dey, Year) MAR 06 1998

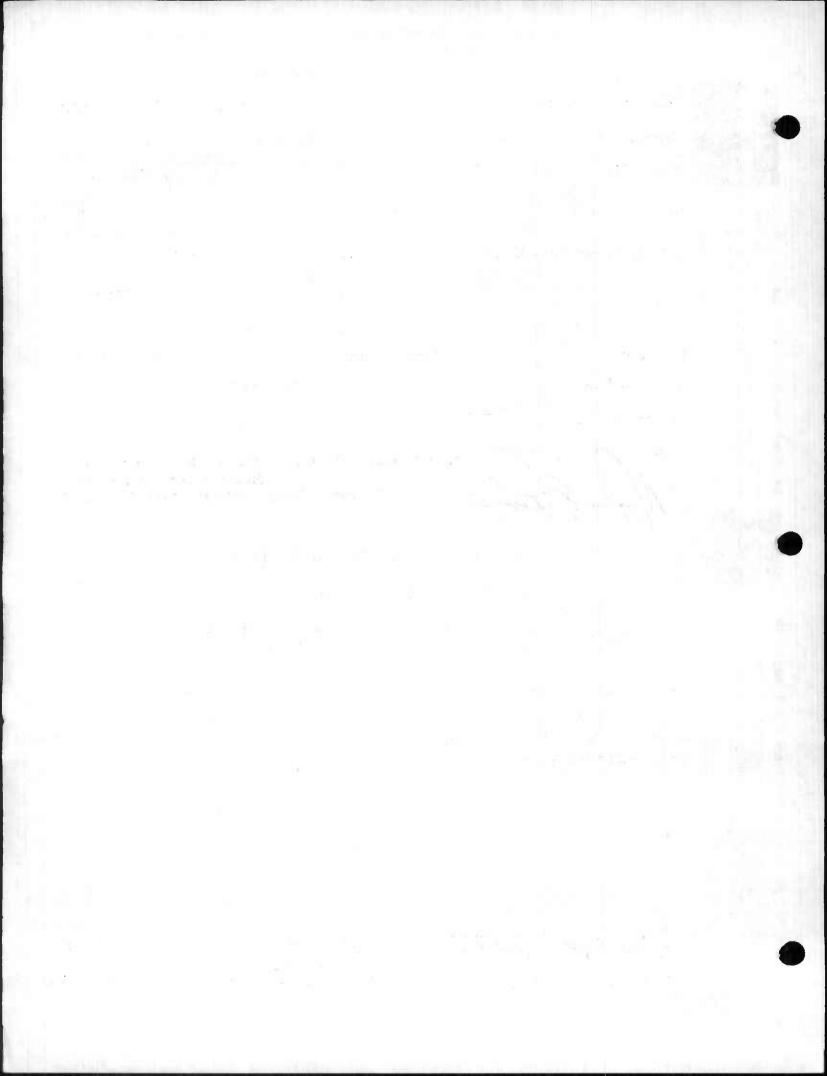
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Anna a Buck a Anna 5 4 New Plant - L. Albert · # · ¥ The second of the second of The state of the s THE RESERVE OF THE STREET The searched in the particular program is the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma	rylanu /	Certificate of			g. No.	8 07173
ľ	Physic		1. Decedent's Nama (First, Middle, I Warren Willia	,				2. Data of Death Month Februa	Day	3. Tima of Death Year 1998 4p.m.
	/Medi Examir		4a. Facility Nama (If not institution, g 120 Mt. Olivet I	,	-		4b. City, Town, or L		4c. County	of Death
	Funeral Director				(in yrs. last b	irthday) If Under 1 Yas Months Day		8. Date of Birth (Month, Day, Februar	y 1, 19	9. Birthplace (Stata or Foreign Country) 925 Md.
Ī	Maryland H show	tor	Usual Rasidence of Decedent 10a. State 10b. County Md . n/a			wn or Location timore				10d. Inside City Limits 12 Ves 2 □ No
	th with the 23a or 28a ust be not	ral Director	10e. Street and Number 120 Mt. Olivet I	Lane North		10f. Zip Code 2122			g. Citizen of V	Vhat Country?
020	n 72 hours efter death with the Maryland "netural", or items 23a or 28s-f show bullest Examinet must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 DM idowed 4 Divorced	12. Was Decedent E- Armed Forces? d □ Yas ②No If Yes, Give Year or Dates:		13. Was Decedent of If Yas, specify Cu	Hispanic Origin? (Spuban, Mexican, Puerto Specify:	ecify Yas or No- Rican, etc.)	Blac	e - Amarican Indian, k, White, etc. Black
Maryland 21215-0020	within ena. then "	Completed	15. Decedent's (Specify only highest of Elamantary/Secondary (0-12) 8th grade	Education grada complated) Collaga (1-4or 5+	-)	a. Decedent's Usual Occ (Giva kind of work don life. DO NOT usa reti	upation e during most of work red)	rorking		ip Trade
and	be filed d othe event,	Be	17. Father's Name (First, Middle, La Harold Williams	est)	120	ingonor catari	18. Mother's Nam Viola Oua	e (First, Middle, N		
land	d 2 should be it and Mental it is marked or traumatic even	To	19a. Informant's Name/Relationship	o (Type, Print) daugh	ter 19	b. Mailing Addrass (Stre	et and Number or Rur	ai Route Number,		
	70		Vanessa Dawson 20a. Method of Disposition			2907 MA of Disposition (Name of ery, cramatory or other p				4D. 21230 City or Town, Stata
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other once.		XIDSurial 2 ☐ ofenation 3 4 ☐ Donation 5 ☐ Other (Spe	(ify)		us Memorial		March 4 I	Baltimo	re, Md.
Bal	pemit. Pa Departman Important: any injury once.		21. Signatur curunera Service Lie	tenne	>		ns Falls F	PKWY Balt	cimore,	omes, Inc. Md. 21216
	Physician		23a Part Empth disaase, co	om fications that of usad t ily ona causa on each line	he daath. Do	not entar the moda of d	ylng, such as cardiac	or raspiratory arre	st,	Approximata Interval Between Onset and Death
	/Medical Examiner		Immadiate ause (Final diseasa or condition resulting in death)			CORDIAL 1	NEWLIT	IN		MUUTES
-	be sit	Examiner				consequence of):	DISEASE			Yems
ox 68760,	certificate be axecuted nding physician end usa as the burial-transit	edicai	Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	D	ue to (or as a	consequence of):	MOIDU DISERSE	schun	1	Tems
D. Box	e daath cert the ettending hed for usa	Physician/M	Part II. Other significant conditions	contributing to death but	not resulting	In tha undarlying cause (givan In Part I.	23b. Did tol	bacco use con	ntribute to the cause of death?
s, P.O.	s thet the da ined by the e e detached i	y Ph	EMMINSUM			1700	1 Yes 2 No 3 Probably 4 Unknown			
Division of Vital Records,	The law requiras thet the daath cer ate has been signed by the ettendin page 2 should be detached for usa	Completed by	CONDIUMY UPA	24a. Was ar perform		24b. Were autopsy findings available prior to complation of causa of daath?				
talR	nysician: The lav ils certificate hes director, pege 2		25. Was case referred to medical	•			Of Place of Death	1 🗆 Ye		1 Yes 2 No
<u>S</u>	hysicia tris cert	To Be	examiner?	Hospital: 1 Inpatian		dipatient 3L DOA	Other: 4 Nursing Ho	th (Check only one	nce 6 Othe	
ision	To the Hospital or Attending Physician: while 24 hours also begins also begins To the Funnal Director, After this certifica completaly illied, in the fungial director,	Certification:	27. Manner of Death 1 Natural 5 Panding 2 Accident Investigati 3 Suicide 6 Could not datamine	be 29a Blace of Injur	Year)		ork? ☐ Yes 2 ☐ No	28d. Describe ho		ed er or Rural Route Number,
á	Atal or uns after		• 🗆 nomicide	building, atc.	(Spacify)			City or Town	, State)	
	To the Hospital or A within 24 hours after To the Funeral Direction pleasing filled in the Funeral Direction pleasing filled in the Funeral Direction pleasing filled in the Funeral Direction pleasing filled in the Funeral Direction pleasing filled in the Funeral Direction Plant Pla	edical	29a. Certifier (Check only one) Certifying F 2 Medicat Example 1	Physicien: To tha best of aminer: On the basis of e and manner state	xamination at	a, death occurred at the nd/or investigation, in my	time, data and placa, oplnion, daath occur	and dua to tha ca red at the time, da	usa(s) and ma ta end place, a	nnar as statad. and dua to tha cause(s)
	To t To t	M	29b. Signature and title of certifier	1. MM	M		135			(Month, Day, Year) 2, 1997
	5		30. Name and addrass of person who	1. SWIT 1			STE 201	DATI	nuns	MD 21231
	Sta Registr		31. Data filed (Month, Day, Year) MAR 0 6 19	32. Registrar	s Signature	-Randall				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedant's Neme (First, Middla, Last) Month 1 2. Date of Deeth 3. Time of Death Jay Ralph Wood 132 4e. Fecility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death Cockeysville Middle School Cockeysville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
November 7, 1962 Vinginia 5. Sociel Sacurity Number 7. Age (In yrs. lest birthday) Birthpiace (Steta or Foreign Country) **X**XM 2□ F 35 Yrs. 252-31-1465 10a. Stata 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yas X No Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13010 Gent Road 21136 USA 12. Wes Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yas, Give Yeer or Detes: Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Marital Status 1 Never Merried 2 Married 1 Yas 2 XNo Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usuei Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) College (1-4or 5+) Elemantary/Secondery (0-12) Maintenance Engineering 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumema) James Ralph Wood Nancy Padgett 19a. informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) James R Wood Father 13010 Gent Road Reisterstown Maryland 21136 20b. Place of Disposition (Nema of cematary, crematory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Stata Fort Hill Memorial Park | 3/4/98 | Lynchburg, Virginia nature of Funeral Sprvice Licenses 22. Name end Addrass of Facility Mitchell-Wiedefeld Home Inc. 6500 York Road Baltimore, Maryland 21212 cal ons thet causad tha daath. Do not antar the moda of dying, such as cardiac or raspiratory errest, as causa on each line. Approximate interval Between Onsat and Death immediata Cause (Finai Grom Hanging diseese or condition rasulting in daath) Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaase or injury that initiated evants rasulting in death) Lest Dua to (or as a consequance of): Dua to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Was an autopsy 1 Yas 2 Ak 1 ☐ Yas 2 ☐ No 25. Was case referred to medical axaminer? 26. Piaca of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Mennar of Death 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

1 | Yes 2 | → NO

29d. Dete signed (Month, Day, Year)

CANGO TY AND GARAGE AND A CONTROL OF THE PROPERTY OF THE PROPE

29c. Licensa number

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within Department of Health end Mental Hygiene. Important: If hem 27 is marked other than "resny injury or other traumatic event, the Heal

the Maryland

death with

Maryland 21215-0020

Baltimore,

physician and the burial-transit

Physician/Medical þ Completed Be Medical Certification: To

1 Naturai

2 Accident

3 Deuicide

29b. Signature and title of certifier

29e, Certifian

Box 68760 for use as P.O. signed by i Records, page 2 should b this certificate of Vital l or Attending Physician: after death. Director: After this certifica Division To the Hospital within 24 hours To the Funeral completely filled

State Registrar 9). Name and address glaterson who completed cause of death (Item 23a) (Type, Print)

3-2.97

31. Data filed (Month, Day, Year) MAR 06 1998

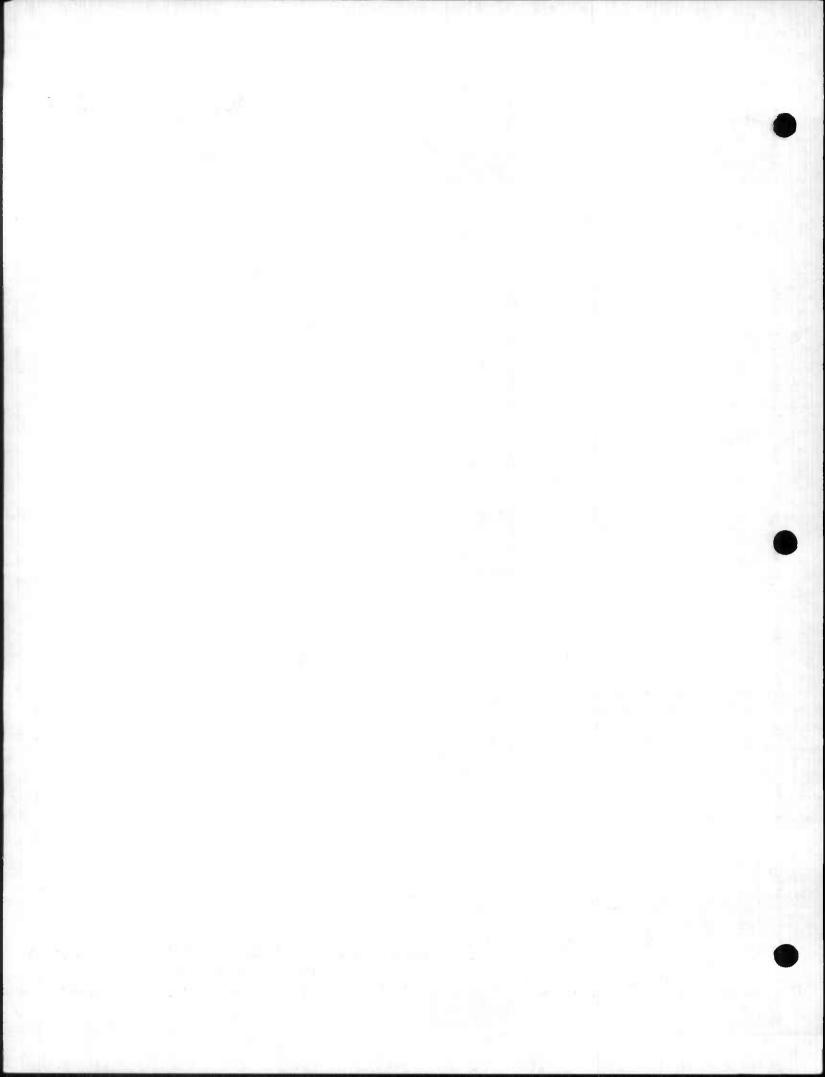
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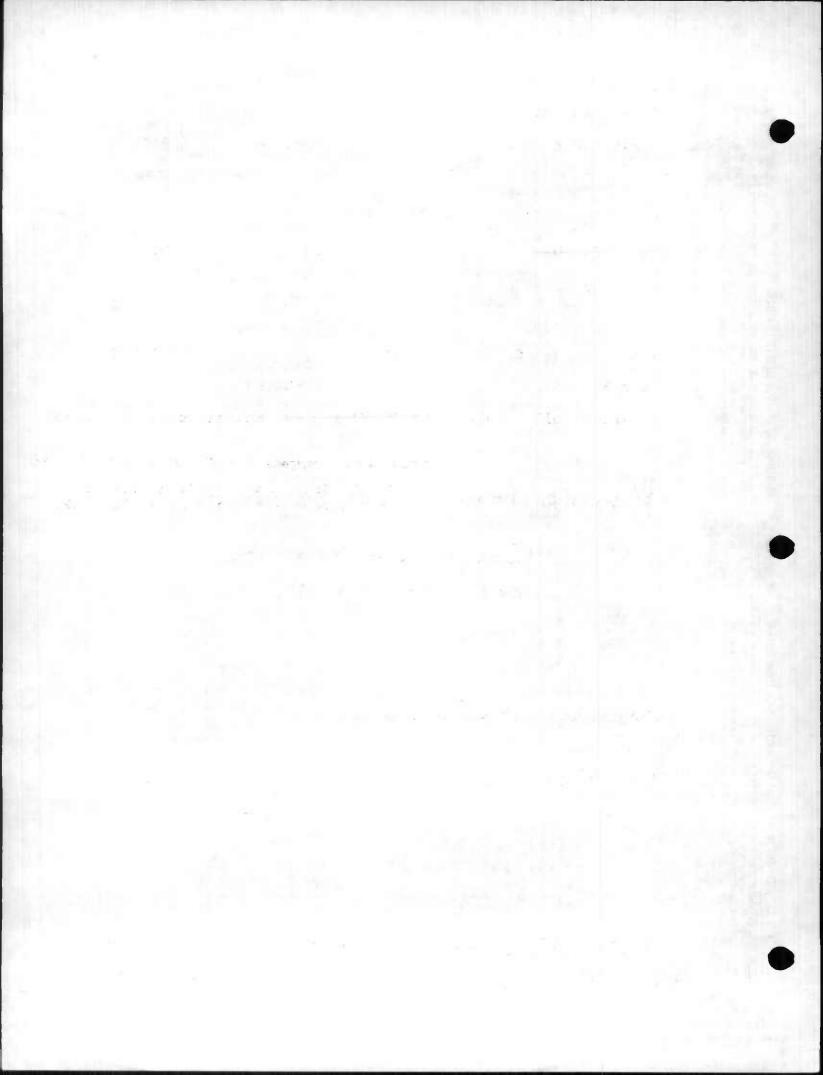
nstrar's Signatura Pandell

28e. Piace of injury - At homa, farm, straet, fectory, office building, atc. (Specify)

DHMH 16 Ray 6/95



							Cer	tificate of	Death		Reg. No.	U	1113	
		Decedant's N	eme (First	t, Middle, La	ast)					2. Data of De Month		Yaar	3. Time of De	
۱ ا		James Wallace										998	1:30	
James Harrace										4c. County	of Death			
					Care	A 11 1		If Under 1 Veer	Baltim			timo		
5. Sociel Security Number 6. Sax 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 189										placa (State or F ntry)				
	Ust	uel Residence	e of Daced	dent	x = 100 102 ms					Aug.	11 1894	+ V	A	
Director		a. Stata MD		County ALTIM	MOD F		Town or Loc						10d. Insida City I	
				WPITI	TORE	DALLS	ALLSTOWN							
	106	3703		A ROZ	AD . 7.00			10f. Zip Coda 211	33		10g. Citizan of USA	What Cou	ntry?	
-	11	Maritel Statu			3703 VEGA ROAD					Specify Yes or No		ce - Ameri	can Indien,	
	1"	1 Never M		Married	Armed Forces? 1 □ Yas 2 □ No			13. Was Dacedeni of Hispenic Origin? (Sp If Yas, specify Cuban, Maxicen, Puarto					k, Whita, atc.	
To Be Completed by Funeral		3 Widowe	d 4□D	ivorced	If Yes, Give Year or Dal	If Yes, Give Year or Datas:			1 ☐ Yes 2 XNo Specify:			BL		
		/9/		ecedent's E	ducation 16a. Dece			ant's Usual Occu	pation during most of wo	orkina	16b. Kind of B	Susinass/In	ass/Industry	
mpie	E	Elementary/Se			Cotlege (1-	(1-4or 5+) life. DO NOT use			OT use retired)					
		1st Fathar's Nan	na /First	Middle 1 and	NA		LAE	BORER	18 Mathada Ma	ma (First, Middle		CONSTRUCTION		
Be C	1	FEL IX			•				UNKNOW		. maideir Guniai			
0							19b. Maltin	Addrass (Stree			er, City or Town	, State, Zij	p Code)	
		19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State Christine Powell - Daughter 3703 VAGA ROAD Randallstown, Mc											21133	
	208	20a. Mathod of Disposition 20b. Place of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition (Name of Disposition One Disposition (Name of Disposition Dis											own, Stata	
		1 ☐ Gramation 3 ☐ Removel from Stata										s Mi	11s. M	
ì	21.	21. Signature of Funeral Service Licensea 22. Nama and Addrass of Facility												
		Wm. C. March Funeral Home West, Inc.												
		DU	Une	2	s. Har	mi								
	23	a. Part1. Enta	ar the disa	nasa, or com	nplications that ce	used tha daath	43	300 Wab	ash Ave	. Balt	imore,		21215 Approximata Interval Batwe	
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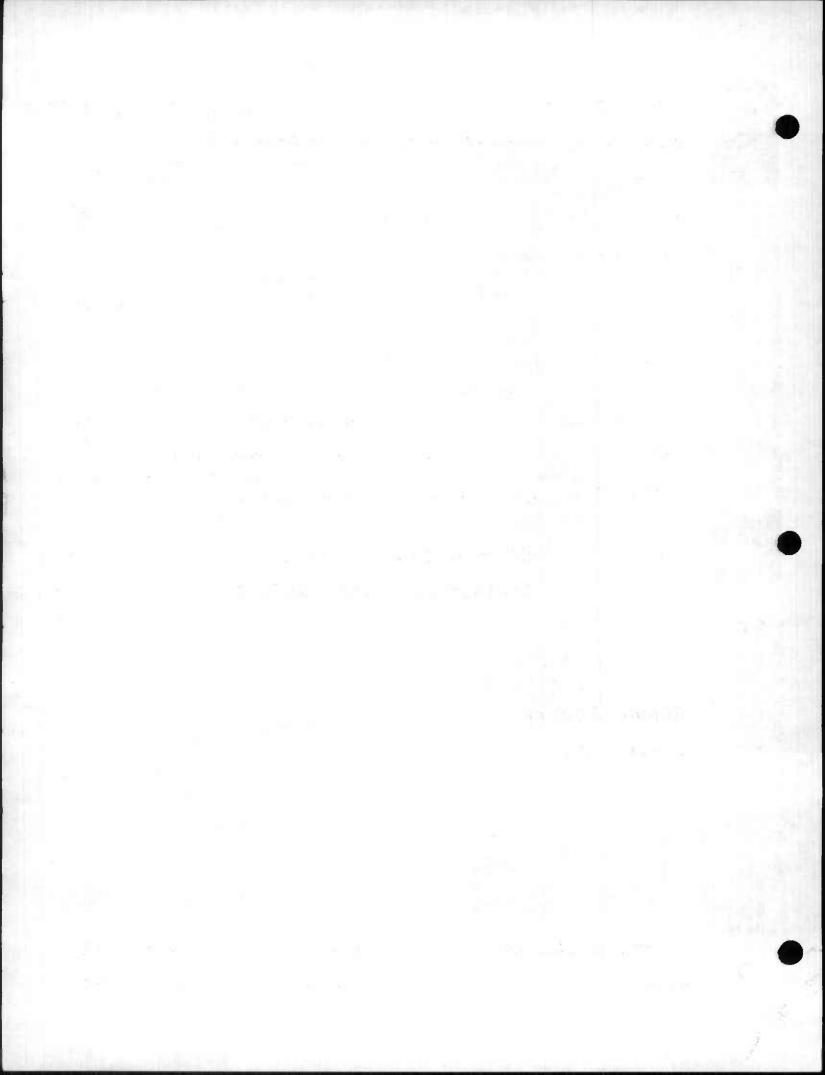


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dey Watkins Yeer

Physician
/Medical
Examiner

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27, Washington Elmer 98 2:40pm Feb. 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Mariner Health North Arundel Glen Burnie II Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 09-13-13 Anne Arundel if Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 1□ M 2□ F X X Months Days Yrs. 84 AŔ 549-34-3950 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Glen Burnie 1 ☐ Yes 2X No 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 21061 USA 368 Turners Lane 12. Was Dacedent Ever in U,S.
Armed Forces?

Markes 2 □ No
If Yes, Give
Year or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) College (1-4or 5+) Disabled unemployed 12th Grade 18. Mothar's Nama (First, Middla, Maidan Sumame) 17. Father's Name (First, Middle, Last) Clara Unknown William Washington 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances H. Washington 20a. Method of Disposition 368 Turners Lane Glen Burnie, Maryland 21061 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Md *Burial 2 Cremation 3 Removal from State Crownsville VA Cemetery 03-06-98 Crownsville, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licenses Valencia 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each lina. WM.C.MArch FH 1101 E. North Avenue Approximata Interval Between Onset and Death Immediate Causa (Final disease or condition rasulting in death) mons cell Carcina Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): horeun a 23b. Did tobacco use pontribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yee 2 No 3 | Probably 4 | Unknown 24b. Ware autopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 120 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident

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Physician /Medical

Examiner

Examiner

Physician/Medical

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Certification: To

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3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Physician

' /Medical

Examiner

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Expression must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Intervention if I leam 27 is merked other than "natural", or flee any Injury or other traumatic avant.

Baltimore, Maryland 21215-0020

tha Maryland

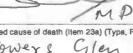
death

Box 68760. Records, P.O. Division of Vital funaral Aftar Attanding al or Attanding s after death. To the Hospital within 24 hours a To the Funeral C Hospital

Registrar

MAR 06 1998

Could not be determined



29c. License number D14136

Certifying Physician: To tha best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

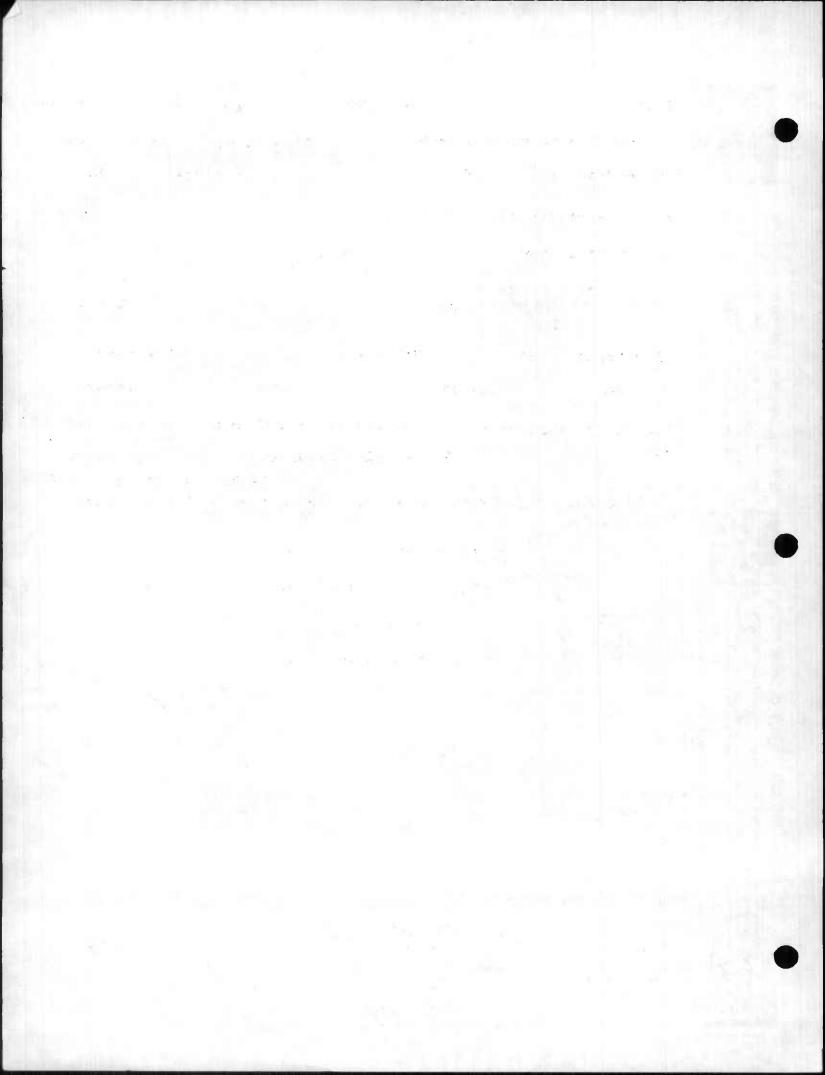
> 29d. Date signed (Month, Day, Year) 2-27-98

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Nama and addrass of person who completed cause of daath (Item 23a) (Typa, Print) DALJIT S. SAWHNEY Suite 201 Crain Tawers Glen Pourmie and 21061: Glen Burnie Suite 201 Towers 31. Date filed (Month, Day, Year)

32. Registrar's Signature relia Davidson Mandall

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

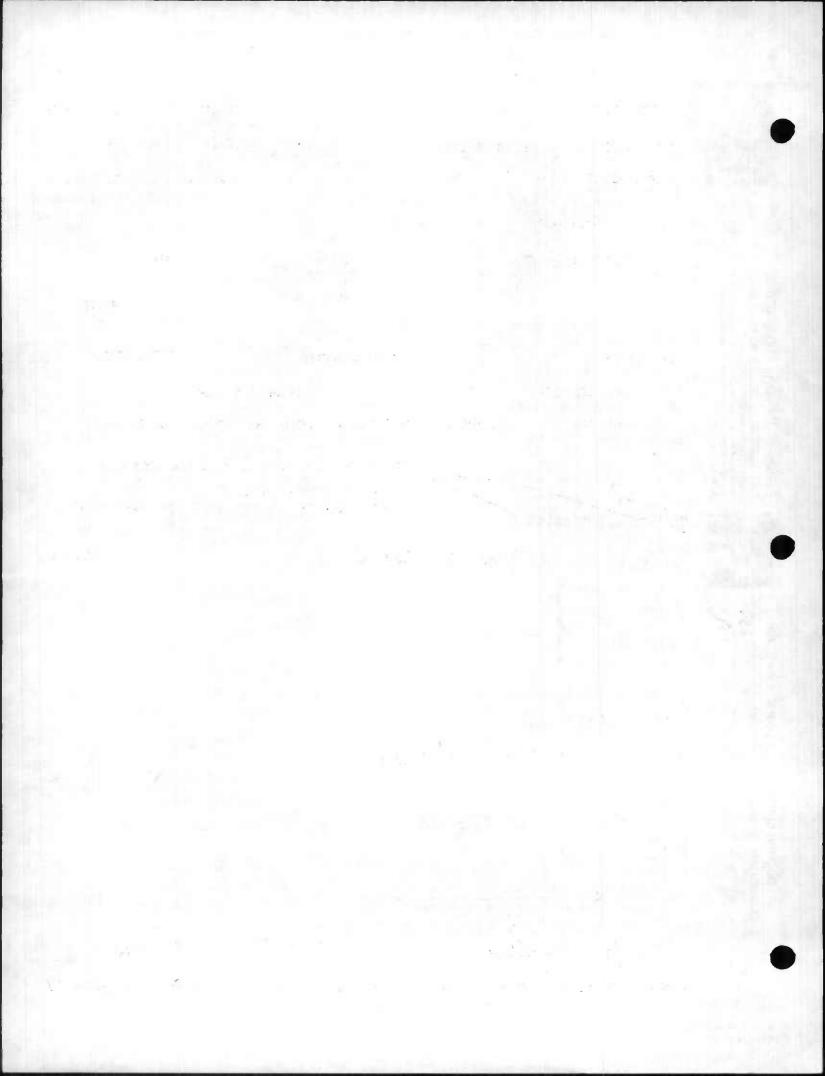
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year **Physician** MARY REGINA WILHELM 1998 MARCH 7:20 P.M. /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE CITY N/A GOOD SAMARITAN NURSING CENTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 K F Yrs Director 212-30-2219 94 3/23/03 MARYLAND Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rithan "naturel", or items 23s or 28s-f show the Medical Examener name be notified at 1 ☐ Yes 2 XNo Directo BALTIMORE PARKVILLE 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code with 7917 OAKDALE AVENUE should be filed within 72 hours efter death ond Mental Hygiena. marked other than "naturel", or items 23 Funeral 21234 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2X No Specify: Specify: þ 3℃ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DEPT. STORE 8th GRADE GIFT WRAPPER 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 should be f and Mental 8 UNKNOWN BURSICK 2 CATHERINE KRAUS 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) of Health an . LOIS KAUFMAN DAUGHTER 7917 OAKDALE ROAD BALTIMORE, MD 21234 other 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If fler
any Injury or ott 1 Buriel 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) DULANEY VALLEY MEM. GAR. 3/6/98 COCKEYSVILLE, MD 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Parts. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Upper GI bleed **Examiner** Due to (or as e consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es a consequence of) The law requires that the death certificate be Due to (or as a consequence of) signed by the e 23h. Did tohacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yes 2 No 3 □ Probably 4 □ Unknown dementa þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Was en eutopsy performed? anemia of emproun etidogy Completed 1 ☐ Yes 2 No certificate Division of Vital Physician: 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death

1 Straturel

2 Accident 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 5 Pending Investigation or Attending death. 1 ☐ Yes 2 ☐ No Director: A 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide 24 hours aft Funeral Di letely filled In Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) within 2 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVEN BLUD BALTO, MD. 2/239 SPERLING, M.D. 5601 LOCH 31. Dete filed (Month, Dey, Year) State 06 Registra



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death #5 per FH G757 3/17/98 EW 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** MARY ELIZABETH WEST MARCH 3, 1998 5:30 AM /Medical 4a Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3547 BENZINGER ROAD BALTIMORE N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Deys Hours 300-16-5730 1 ☐ M 2 🖾 F Yrs. **Director** AUG 27,1911 86 OHIO Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 □ No Directo MD N/ABALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or any injury or other traumatic event, the Medical Exercitive marks to once. 3547 BENZINGER ROAD 21229 Funeral U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3√2 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE FACTORY WORKER WARDS 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) MATHEW SHELTON TDA CRUSE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) JOHN LAFFERTY (SON-IN-LAW) 3547 BENZINGER ROAD - BALITMORE, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) LOUDON PARK CEMETERY 3/5/98 BALTIMORE 21. Signature of Funeral Service Liceos 22. Name end Address of Fecility
HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 23a. Part1. Enter the disease, or complication that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart feilure. List only one durie on each line. **Physician** /Medical Immediate Ceuse (Final 0+ Carcinoma disease or condition resulting in deeth) Examiner Examine The law requires that the death cartificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): 98 usa signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evellable prior to completion of cause of deeth? should I 24a. Wes en eutopsy performed? Completed his certificata has bai director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of Natural 5 Pending death. 1 Yes 2 No Investigation 2 ☐ Accident or Attendation of Director: 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direccompletely fillad in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier edical

Registrar

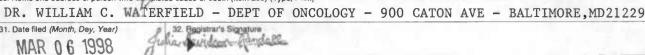
31. Date filed (Month, Dey, Year) MAR 06 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Culal

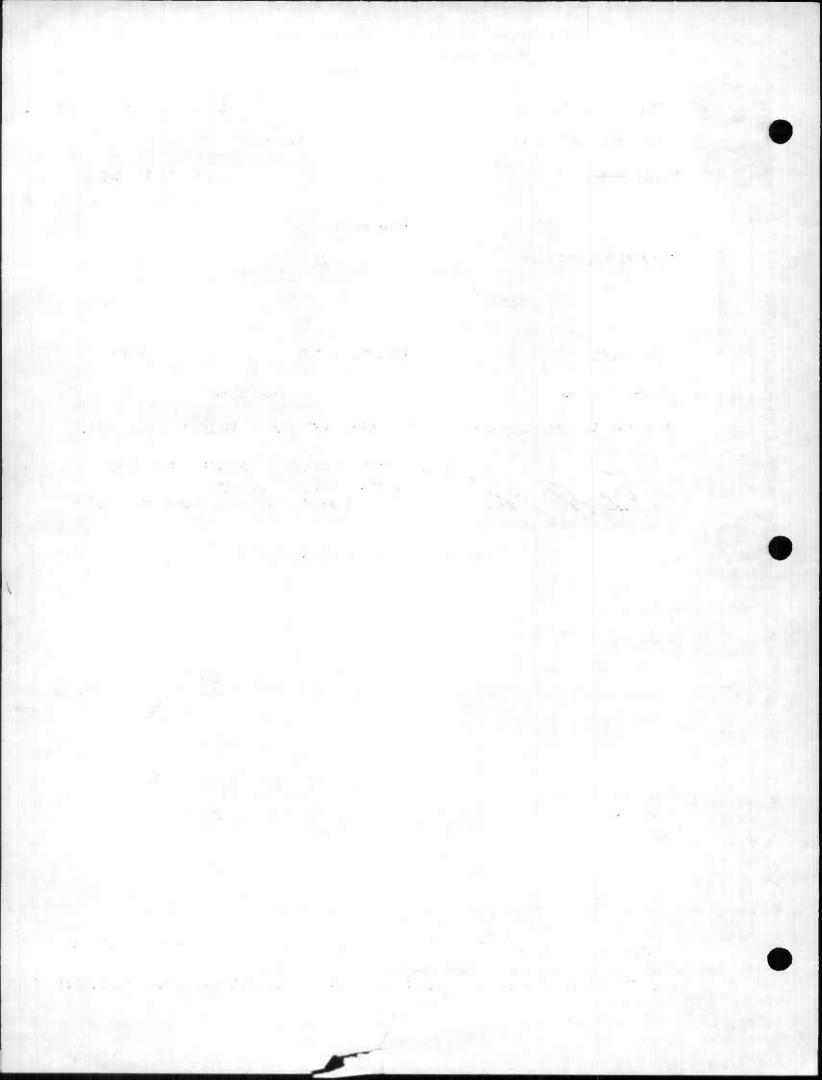
(Check only one)

29b. Signeture and title of certifier



29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

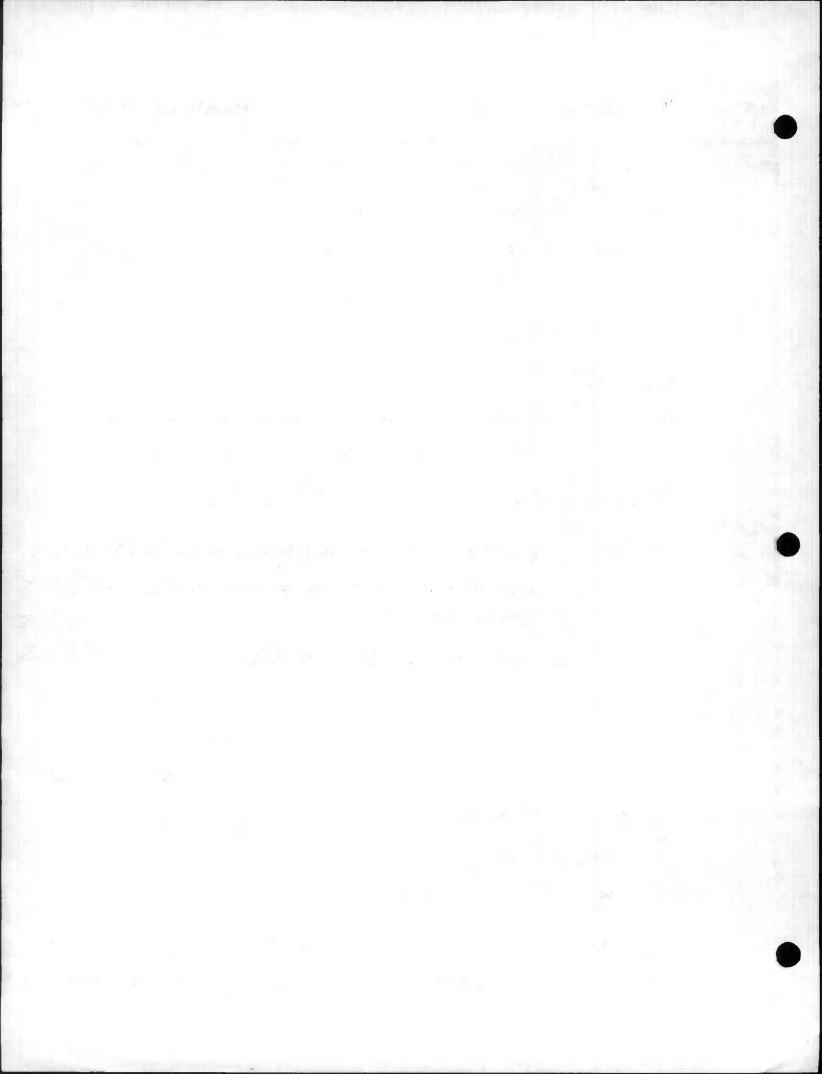
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Death GIRL **Physician** OUNGER BABY 5:30 pw MARCH /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore N/A If Under 24 Hrs. Hours Min. If Under 1 Year 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Deta of Birth (Month, Day, Year) **Funeral** Months Hours 5 1 ☐ M 2 € F N/A 30 Director 3-1-98 MD Usuel Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Experience must be notified at MD Baltimore Essex Director 1 Yas 2 No 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? with 1607 Dartford Rd. Apt. C 21221 USA Funeral filed withIn 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Maritel Stetus 14. Race - American Indian, Black, Whita, atc. □Yas 2□No Yas, Giva 1 Navar Marriad 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 1 No þ Specify: black 3 Widowed 4 Divorcad "natural", Year or Datas: Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Dacedant's Education (Specify only highest greda completed) 16b. Kind of Businass/Industry pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event Elementery/Secondary (0-12) Collega (1-4or 5+) 0 0 N/A N/A 17. Father's Nema (First, Middla, Lest) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Tyvon Smith Alicia Younger 10 19a. Informant's Name/Relationship (Typa, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Alicia Younger / mother 1607 Dartford Rd. Apt. C. Baltimore, MD 21221 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 X Cremation 3 ☐ Ramoval from Stata Metro Crematory 3-6-98 Catonsville, MD 4 Donation 5 Othar (Specify) 21. Signature of Funarai Sarvica Licenses 22. Nama and Address of Facility ells Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237 23e. Part1. Enter the disease, or complications that a used the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line. **Physician** CARDIOGENIC SHOCK (Myocordial failure) /Medical Immediate Ceusa (Final diseasa or condition rasulting in daath) Examiner Due to (or es a consequence of):

RESPIRATORY DISTRESS SYNDROME Examiner physician end the bunal-transit The law requires that the death certificate be executed Saquentially list conditions, if any, leading to immadiate causa. Enter Undarlying Causa (Disaesa or Injury Box 68760 Physician/Medical that initiated avants rasulting in daath) Lest Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Ware autopsy findings available prior to complation of cause of deeth? 24a. Was an autopsy performad' hes 200 No 1 Yas 2 No certificate 1 Yas or Attending Physician: funeral director, 25. Was casa raferred to medical axaminar? Be 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Certification: To 1 Yas 25 No Inpatiant 2 ER/Outpetiant 3 DOA this 27. Menner of Death 28a. Data of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred After 5 Pending invastigation 1 Watural efter death. 1 TYas 2 No 2 Accident 6 Could not be detarmined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida • Funeral Medical 29a. Cartifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mennar as stated. To the Hoap within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the causa(s) and manner stated. 29b. Signatura end titla of certifier 29c. License numbar 29d. Dete signad (Month, Dey, Yaar) PA 30. Nema and address of person who completed causa of daath (Item 23a) (Type, Print) HOPKINS BAYVIEW MEDICAL CENTER BALTMORE, MD 21224 31. Dete filed (Month, Day, Year) 22. Ragistrar's Signature State who Davidson-Randall

DHMH 16 Rev 6/95

Registrar

0 6 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			3.4	C	ertificate of	Death		g. No.	071	
Physicia /Medic		Decedent's Neme (First, Middle, L JERRY EDV	VARD ATKINS				2. Dete of Deeth Month FEB 1	Dev	Yeer	3. Time of Death 6:21 AM
Examin		4e. Fecility Neme (If not institution, gr NATIONAL NAVAL N		ER		4b. City, Town, or Lo BETHES1		4c. County MO	of Deeth NTGOME	RY
Funeral Director			Sex 7. Age (fr ↑ 2□ F 60	yrs. last birthde Yrs.	y) If Under 1 Yeer Months Deys	if Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, NOV • II	,1937	9. Birthplac Country Washii	e (Stete or Foreign
show	20	10e. Stete 10b. County		c. City, Town or					10d.	Inside City Limi
3e or 28e-f	Funeral Director	Maryland Prince 10e. Street end Number 6222 Auth Road	George's	Suitla	10f. Zip Code	746	10	g. Citizen of V		1 □ Yes 2 💢 I
randus ener deam with the Melyland netural, or items 23s or 28s-f show dical Examiner must be notified at		11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? ↑ XYes 2 No 11 Yes, Give Yeer or Detes: 1	1957	3. Wes Decedent of H If Yes, specify Cube	lispenic Origin? (Spe an, Mexican, Puerto Specify:	ocify Yes or No- Rican, etc.)		e - American ck, White, etc	
iene. Than "netural". The Wedical E.	Completed by	15. Decedent'e E (Specify only highest g Elementary/Secondary (0-12)	Educetion	(Gi	cedent's Usuel Occup ve kind of work done . DO NOT use retired U.S. Army	during most of worki d)	ng 1	6b. Kind of Br	usiness/indus	stry
ital Hyg d other	To Be Co	17. Fether'e Neme (First, Middle, Las Garland Westbe			O.S. ALINY	18. Mother's Neme	(First, Middle, M	leiden Sumem		cnment
Ith el		19e. Informent's Neme/Reletionship Regina Mae Atk			olling Address (Street 222 Auth F					ode)
9 4 4 9		20e. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Special Control Co	Removel from Stete	20b. Plece of Dis	position (Neme of remetory or other plea On Nationa	Feb. 1	90,01998 2	Oc. Location -	City or Town	. Stete irginia
Department Important: 1 any Injury o		21. Signature of Filheral Service Lice	a you	/	22. Neme end Addre	10	e Funera Ferry I			
hysician /Medical Examiner	ner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only fmmediate Cause (Finei disease or condition resulting in death)	e. NON S		CLL LUNG C				0	terval Between nset and Deeth
physicie	/Medical Examiner	Sequantielly list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initialed events resulting in death) Lest	C	to (or es e cons						
the attending	Physician/M	Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying cause giv	ven in Pert I.	23b. Did tot	DACCO USO CO	ntribute to th	e cause of des
	by Phy						1 □ Ye	8 2□ No	3 Probet	oly 4 Unkn
2 s b	Completed	-					24e. Wes an perform	eutopsy ed?	avalle	eutopsy finding oble prior to letion of cause ath?
pag	Be Cor	25. Wes cese raferred to medicel				26. Piece of Deeth		s 2 No	1 🗆 Y	es 21 No
his	2	examiner? 1 Yes 2 No	Hospitel: 1 Xinpatient	2 ER/Outpet		ner: 4 Nursing Hor	me 5 Resider	nce 6 Oth		
after death. Director: After th d in by the funeral	Certification:	27. Manner of Deeth 1. Natural 2 Accident 3 Sulcide 4 Marrielde	28a. Plece of Injury -	At home, ferm,	M 1	Yes 2 □ No	28d. Describe hor	eet end Numb		loute Number,
within 24 hours after To the Funeral Directory	edical Cert	29e. Certifier 1 Certifying Pl	building, etc. (S hysician: To the best of my minar: On the basis of exa	y knowledge, de	eth occurred at the tir	ne, dete end plece, e	City or Town,	use(s) end ma	annar as state	ad.
within 2 To the Complet	Med	one) 29b. Signeture end title of certifier	end menner steted.		29c. Licens			d. Dete signe		
1 5 6 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		01/10	10/		RES-			Feb 17		
					1000				160 60 8	

DHMH 16 Rev 6/95

James Charles STATE THE STATE OF

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Deeth Dev Month **Physician** Thelma Kathleen Blank FEBRUARY 26, 1998 01:15AM /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Allegany Sacred Heart Hospital Cumberland Birthplace (State or Foreign Country) 5. Sociel Security Number 219-14-5294 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 24-Mar-24 **Funeral** Months Deys Hours 1 M 2 F 73 Director Maryland Usuei Residence of Deceden with the Marylend 10d. toside City Limits 10e Stete 10c City Town or Location 10b County 28a-f show 7 is marked other than "naturel", or flams 23s or 28s-f show traumatic event, the Modical Examiner must be notified at Allegany 1 XYes 2 No Maryland Mount Savage Director 10e. Street end Number 15408 Weimer Drive, N.W. 10f, Zip Code 10g. Citizen of What Country? 21545-II.S.A. Funerai death 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status Peges 1 and 2 should be filed within 72 hours effer of nent of Heelth and Mentel Hyglene. Int: If Item 27 is marked other than "naturel", or Ite 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No altimore, Maryland 21215-0020 Specify: Specify.White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be **Doualas Porter Nellie Wright** 0 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. tnforment's Name/Reletionship (Type, Print) James Austin Blank, Sr. Husband Mount Savage Maryland 21545-5408 Weimer Drive, N.W. other 1 20b. Piece of Disposition (Neme of cametery, cremetory or other placa) 20e. Method of Disposition

1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Dete 20c. Location - City or Town, Stete 6 Department of Important: If any injury or St. George's Episcopai Cemetery 28-Feb-98 Mount Savage, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service License 22. Name end Address of Fecility hu Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Final acute CVA diseese or condition resulting in deeth) Examiner bulaterally SIP AKA Examiner llet The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): pue buriel-trar Records, P.O. Box 68760 physician Physician/Medicai the Due to (or as e consequence of) esn 0 ed by the e Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the ceuse of death? s been signed by the should be detech-1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown py 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed page 2 hes 20 No 1 Yes 2 No 1 ☐ Yes certificate Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? director Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 0 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menurer of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of After 1 Natural 5 Pending investigation ofter death. Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of fnjury - At home, ferm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide To the Hospital of within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29e. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier , MCCulla FEBRUARY 26, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. H. Caullul 921 Sum Drive Sutt Cumbuland Hd 21502 Sutte nas 31. Date filed (Month, 22, Registrer's Signeture

DHMH 16 Rev 6/95

Registrar

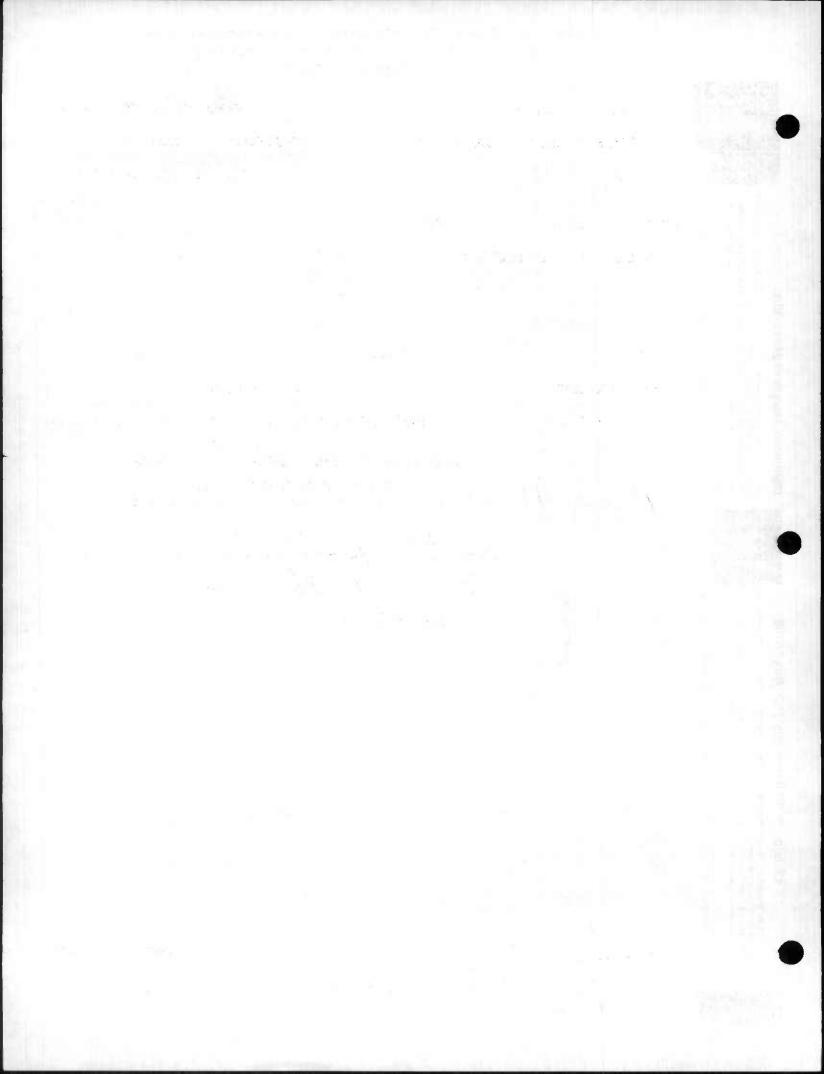
State of Maryland / Department of Health and Mental Hygiene O O

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*		-	Jsuel Residence of Decedent 0e. Stete 10b. Cour			100 0	City, Town or	Location							14		Oh Lin
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DHMH 16 Ray 6/95

State of Maryland / Department of Health and Mental Hygiene Q Q

				C	ertificate	of Death		Reg. No.	0/184
Dhuata		1. Decedent's Name (First, Middla, Last)				2. Dete of Dee	eth	3. Time of Death
Physic /Medi		MARY JANE BA	ARRY					ARY 23 19	
Exami		4a. Facility Name (If not institution, giva	street and number)			4b. City, Town, or		4c. County of	f Deeth
		SACRED HEAR				CUMBER		ALLEGA	
Funeral Director		5. Social Security Number 6. Sec. 216 14 1443 Usual Residence of Decedent	7. Ag	76 Yrs	Months D	eer If Under 24 Hrs ays Hours Min.	8. Date of Birt (Month, Da) JUNE 28	y, Year) B 1921 N	Birthplece (Stata or Foraign Country) IARYLAND
Aerylend I show	or	10a. State 10b. County	_	10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
the N	Director	MARYLAND ALLEGANY 10e. Street and Number	<u> </u>	FROST	BURG 10f. Zip Cod	do		10g. Citizen of Wi	
with w			T DDTUE	CU					iet Country?
leath 22	Funeral	10611 LAUREL HI	12. Was Decedent			532 of Hispanic Origin? (S	pecify Yes or No-	U.S.	- American Indian.
13-UUZU 72 hours effer death with the Menylend 7aturel', or Neme 23a or 28a-f show pdical Examiner must be notified at	b	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 Your lf Yes, Give Year or Dates:	No	If Yes, specify of	of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	o Rican, etc.)	Specify:	, White, etc. WHITE
D-C	B	15. Decedent's Edu	cation	16a. De	cedent's Usual O	ocupation	4.4.	16b. Kind of Bus	
Z I Z Z withir ziene. r than	Completed	(Specify only highast grade Elementary/Secondary (0-12) 12	a co <i>mplated)</i> Cotlege (1-4or 5	0+)	iva kind of work di e. DO NOT usa re MEMAKER	one during most of wor tired)	rking	OWN HO	OME
be filed tal Hygid d other	Bec	17. Father's Name (First, Middla, Last)				18. Mother's Nar	ne (First, Middla,	Maiden Sumeme)
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E TO N		FRANK BARRY / SON							RG, MD 21532
0 0 0 0 0		20e. Method of Disposition 1 Buriel 2 Cremation 3 R 4 Donation 5 Other (Spacify)	emoval from State		sposition (Nama o cramatory or other WN MEMOR	place) 2	/26/98 S	LaVALE,	city or Town, State
permit. Peg Department Important: h any injury o		21. Signature of Funeral Sendce License	nos	wens /		FUNERAL HO	-		
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Physician /Medical Examiner		Immediata Cause (Final disease or condition	le ceuse on eech lir	ceete		re Luy	/		Interval Between Onset end Death
اسلا	Examiner	resulting in death)		Due to (or as e con	sequence of):	Ca '	leeve	9,3	untnown
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death cert	clan								
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requir been s should	Completed by						24a. Was a	an autopsy med?	24b. Were autopsy findings available prior to completion of ceuse of death?
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iclan: The	0	25. Was case referred to medical				28. Place of Dea	ath (Check only o		12.103 22.110
ysician: is certifica director,	To B	examiner?	ospital:	nt 2□ER/Outpa	tient 3 DOA	Other		lence 8 Other	(Specify)
		27. Manner of Death 1 Naturel 5 Pending 2 Accident Investigation	28e. Dete of Injur (Month, De)		e of 28c.	njury at Work? 1 □ Yes 2 □ No		ow Injury occurre	
al or Attendi s efter deeth il Director: A ed in by the f	Certification:	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injubuilding, etc.	ury - At home, farm, c. (Specify)	street, factory, off	ice	28f. Location (S City or Tow		r or Rural Routa Number,
To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier (Check only one) Certifying Physical Cartifying Physical Examination (Check only one)	ician: To the best of er: On the basis of and manner ste	examination and/or	eath occurred at the investigation, in r	e time, date and place ny opinion, death occu	, end due to the orred at the time, o	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	Me	29b. Signature and title of dertifler	uia_	W		ensa number			(Month, Day, Year)
3		30. Name and address of person who co	moleted cause of d	noth (Itom 02a) /T	De Drint)	02 11	*	rebruary	OS, ISS
nes		Uriel Velandia	M.D.91	02 Seto	n Dri	ve Cum	berland	1 ND	25, 1998 21502
Sta	te	31. Date filed (Month, Day, Year)	32. Registre	er's Signature					

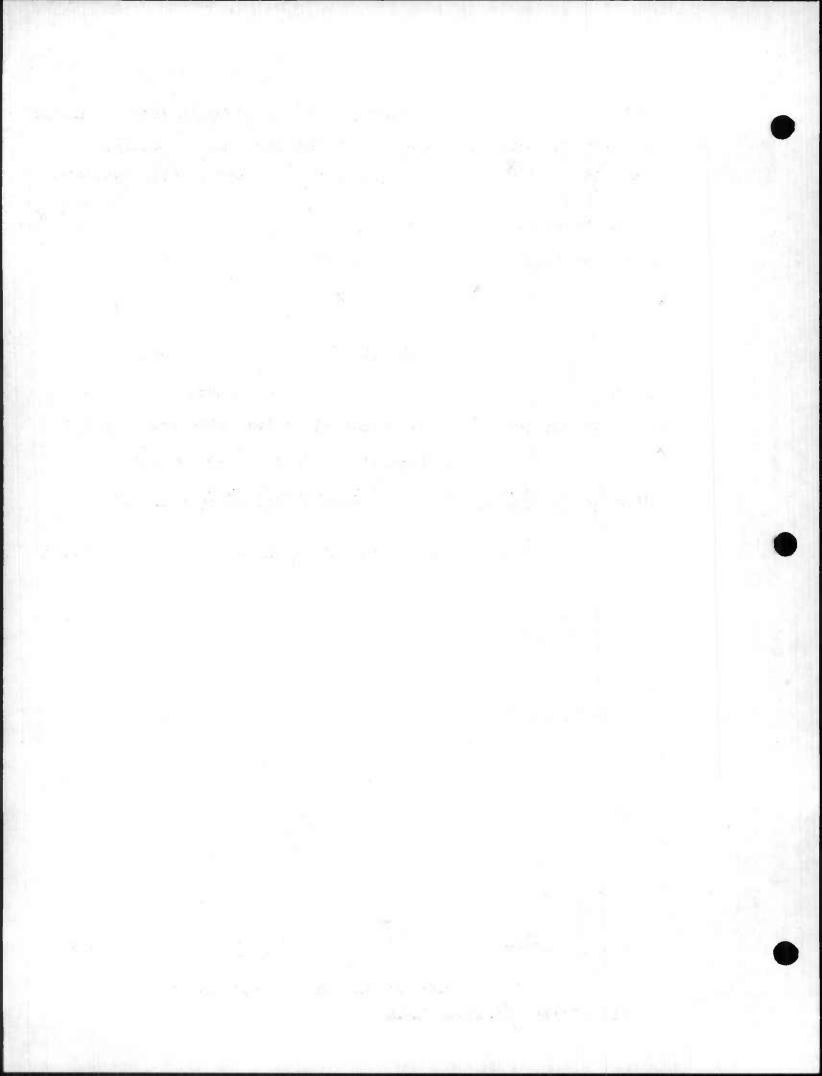


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla: Last) 2. Date of Death 3. Time of Death **Physician** Month Barclay /Medicai Feb 23, 1998 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Center; Genesis ElderCare Salisbury, Md. Wicomico If Under 1 Yaar Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funerai** 1□ M 2XF Days Hours Yrs. Director Maryland 219-05-3629 Mar.7 1920 Usuel Residance of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Quantico 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 25376 Gilies Lane 21856 U.S.A 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 ☐ Divorced Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Domestic None pemit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Unknown Marie Gramham 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Vivian M.Nutter (Daughter) 313 Brookdale Drive Salisbury,Md.21804 20a. Method of Disposition

1 ■ Burial 2 □ Cremetion 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 3/28 4 ☐ Donation 5 ☐ Other (Specify) Springhill Mem.Garden Hebron, Md. 21. Signature of Funerel Service Licensee 22. Nama and Addrass of Facility Stewart Funeral Home
821 West Rd.Salisbury, Md.21801
23a. Part. Enter the difeasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fature. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final NETASTATIC CANCER of CERUX disaese or condition resulting in death) **Examiner** Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last and Due to (or es a consequença of) physician Box 68760 Physician/Medicai Dua to (or as e consequence of): P.O. 1 signed by the sid be detached to Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? TO CANCO 1 Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated. 29e. Certifier 29b. Signatura and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Kine auso 1104 HEALTHWAY DR., SALISBURY, MD 21804 31. Date filed (Month, Day, Year) 32, Registrar's Signature State FEB 25 1998 Tall Stwelson Randall Registrar

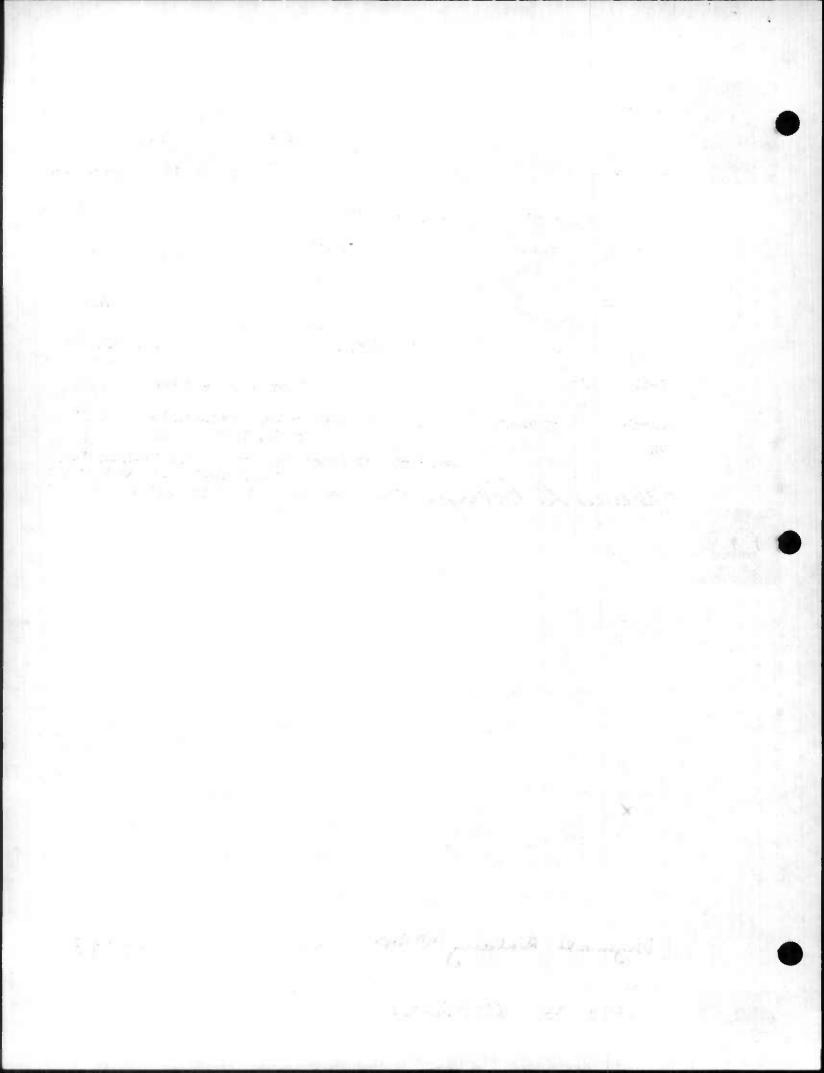
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Physician Month 17 Charles B. Beltz 1998 Feb 7:42pm/Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Deer's Head Center Salisbury Wicomico If Under 1 Year If Under 24 Hrs. B. Dete of Birth (Month, Dey, Year Jan 29, 1 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign **Funeral** Deys Hours XXM 2□F Washington DC 55 Yrs Director 1943 579 54 9447 Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner mant be notified at 1 Yes 2 No Mechanicsville Director MD St. Mary's 10e Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 20659 42185 Patuxent Drive Items 23a United States deeth Funeral 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. should be filed within 72 hours after of Mental Hygiena. merked other than "natural", or her 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 N Divorced White Completed traumatic event, the Medical 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government Electrician 17. Fether's Neme (First, Middle, Last) permit. Peges 1 end 2 should be file Department of Heath and Mental Hy Important: If flem 27 is merked other eny injury or other traumatic event since. 18. Mother's Neme (First, Middle, Malden Surneme) Be Paul B. Beltz Florence Haggenmaker 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 42185 Patuxent Drive, Mechanisville, Md 20659 Catherine E. Haggenmaker 20b. Place of Disposition (Name of cemetery, cremetory or other place) Feb 20, 1898 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Kuriel 2 Cremation 3 Removel from Stete Washington National Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funerel Service Licenses Alexandria Ferry Road, Clinton, Maryland 20735 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Betw Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel Huntington's Disease 18 yrs. diseese or condition resulting in death) Examiner Due to (or es e consequence of): Examiner The law requires that the deeth certificate be executed burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lest Due to (or es e consequence of): Records. P.O. Box 68760. ettending physician for use es the buna Physician/Medical Due to (or es e consequence of): 89 ata has been signed by the e page 2 should be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown Fever unknown origin þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Be Completed 24e. Was an autopsy performed? this certificata Yes 2 No 1 ☐ Yes 2 No of Vital or Attending Physician: offer death.

Director: After this certifica director, 25. Wes case referred to medical exeminer? 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 1 Yes 2 No Certification: To in by the funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Division 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 24 hours 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the ceuse(s) end menner as steted.

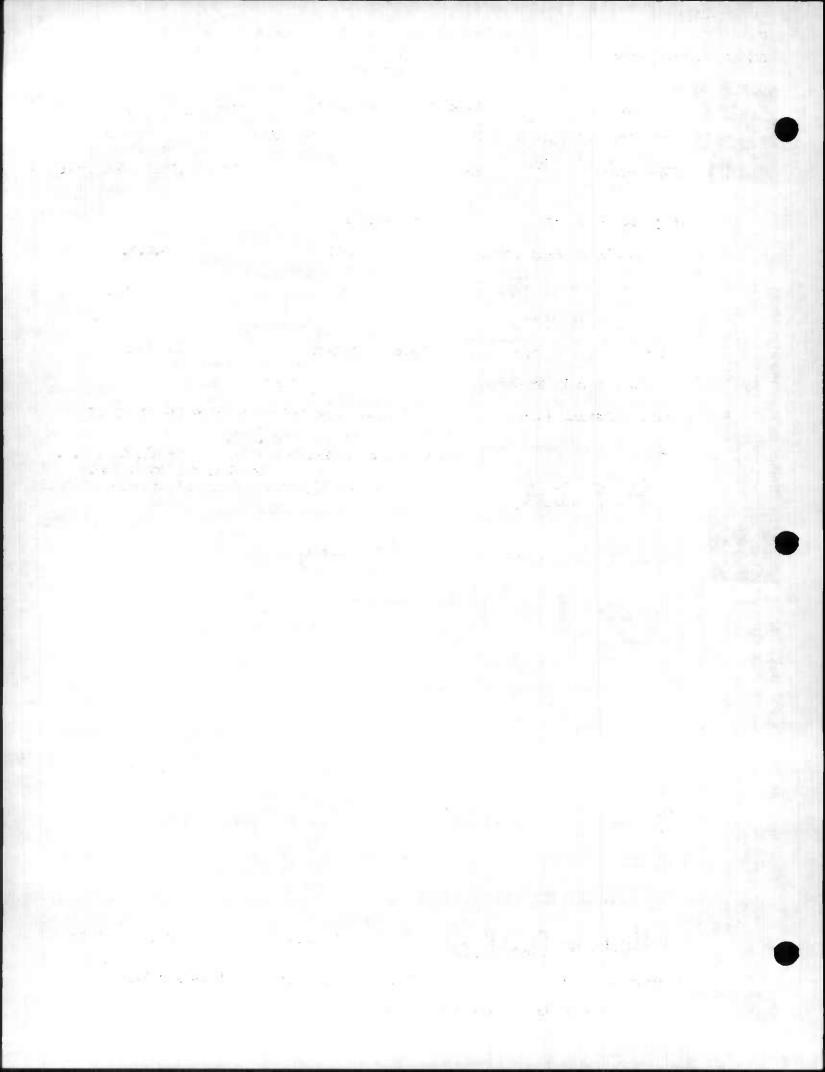
| Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end menner steted. 29a. Certifier Medical completaly To the To the To the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) mo and D 33905 30. Neme end eddress of person who completed cause of deeth (Hem 23e) (Type, Print) V.A. Dulany, M.D., 31. Dete filed (Month, Dey, Year) CMD: P.O. Box 2018; Salisbury, Md. 21802 32. Registrer's Signature State FEB 25 1998 Registrar



DANIEL A, BRODERICK

State of Maryland / Department of Health and Mental Hygiene

TEU A,	BRODERICK		C	ertificate of	Death	R	eg. No. 9 8	01	18	1
	1. Decedent's Name (First, Middle, Las	et)				2. Dete of Deet Month	h Dey	Yeer	3. Tima o	
hysician /Medical	Daniel	Aloysi	ius	Broder	ick		23, 199		5:2	8 AM
Examiner	4e Facility Neme (If not Institution, given PHYSICANS MEMORIA				4b. City, Town, or L Le PLATA		4c. County CHA	of Death ARLES		
uneral rector	5/8-42-7648	7. Age (In yr M 2□ F 63	rs. last birthda Yrs.	Months Deys		8. Date of Birth Month, Day, June 2	5,1934	9. Birthple Countr Wash	ingto	or Foreign
ž	Usuel Residence of Decedent 10e. Stete 10b. County	10c. (City, Town or	Location				10-	d. inside C	City Limits
r 28a-f show Inotified at irector	Maryland Queen Ar	m	Steve	nsville					1 🗆 Yes	21 No
be notified Director	10e. Street end Number			10f. Zip Code		1	0g. Citizen of V		y?	
ral [a	315 Beach Si			21666			U.S.			
"natural", or items 23s or accal Evaminer must be a leted by Funeral Dir	11. Maritei Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:	U,S. 1	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🛣 No		ecity Yes or No- Rican, etc.)	Bled	e - America ck, White, et w: White	tc.	
sical peter	15. Decedent's Ed (Specify only highest gra	fucation	16e. De	cedent's Usual Occu	pation during most of work	kina	16b. Kind of Bu	usiness/Indu	ustry	
nt the Medical ft, the Medical Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retire	9d)		Insula	tion		
	11th 17. Fether's Name (First, Middle, Last)	N/A	Pip	e Cove:	18. Mother's Nam	e (First, Middle, I				
	John Francis				Mary	Wals	h			
traum	19a. informent's Neme/Relationship (Jean Broderick (aiting Address (Stree Beach Sid						
e de	20e. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Specific	Removel from State	cemetery, c	sposition (Neme of remetary or other pla livet Cema	etery :	1998	20c. Location - Washin	gton,	D.C.	
any injury o	21. Signature of Funeral Service Licen	see 4		22. Name end Addr 6633 Old						0735
ial-trensit and mand instrument i	Immediate Ceuse (Final disease or condition resulting in deeth)	b	(or es e con		NY					
g physicia as the bur ledical	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	C	(or es e cons							
for us		u.								
detached for us	Pert ii. Other significant conditions of	ontributing to death but not re	esulting in the	underlying ceuse g	iven in Pert I.		es 2 No			
o before the second signed by the attended for use director, page 2 should be detached for use on Be Completed by Physician/N					F.16-	24e. Wes e perform	PCCON-	com of de	re eutopsy itable prior opietion of eeth?	to
Be C	25. Wes case referred to medical				26. Plece of Dee	th (Check only or				
	exeminer? ▼Yes 2□ No	Hospitel: 1 ☐ inpatient 2	€ R/Outpat	tient 3 DOA	ther: 4 Nursing H	ome 5 Reside	ence 6 🗆 Oth	er (Specify))	
completely filled in by the funeral di Medical Certification: To	27. Menner of Deeth XX Neturei 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be		28b. Time tnjur	y Wo	ury et ork?] Yes 2 □ No	28d. Describe ho				
Certifi	4 Homicide determined	28e. Plece of Injury - At building, etc. (Spe	nome, ferm, cify)	street, fectory, office		28f. Location (Si City or Town		er or Hural	Houre Nur	π <i>0θ1</i> ,
completely filled i		ysician: To the best of my k ninar: On the besis of exami end menner stated.		investigetion, in my	opinion, deeth occur	rred et the time, d	ate and piece,	end due to t	the ceuse((s)
W Com	29b. Signature end title of certifier	Done yhouse			c.M.E	2	9d. Dete signe FEB.	23, 1		
ှင် ခွဲ	30. Neme and eddress of person who Margarita Korell 31. Date filed (Month, Dey, Year)	M.D. 32. Registrer's Sig	111 Pe	0.0	C.M.E		FEB.	23, 1		



Beatrice Charlotte BRADY

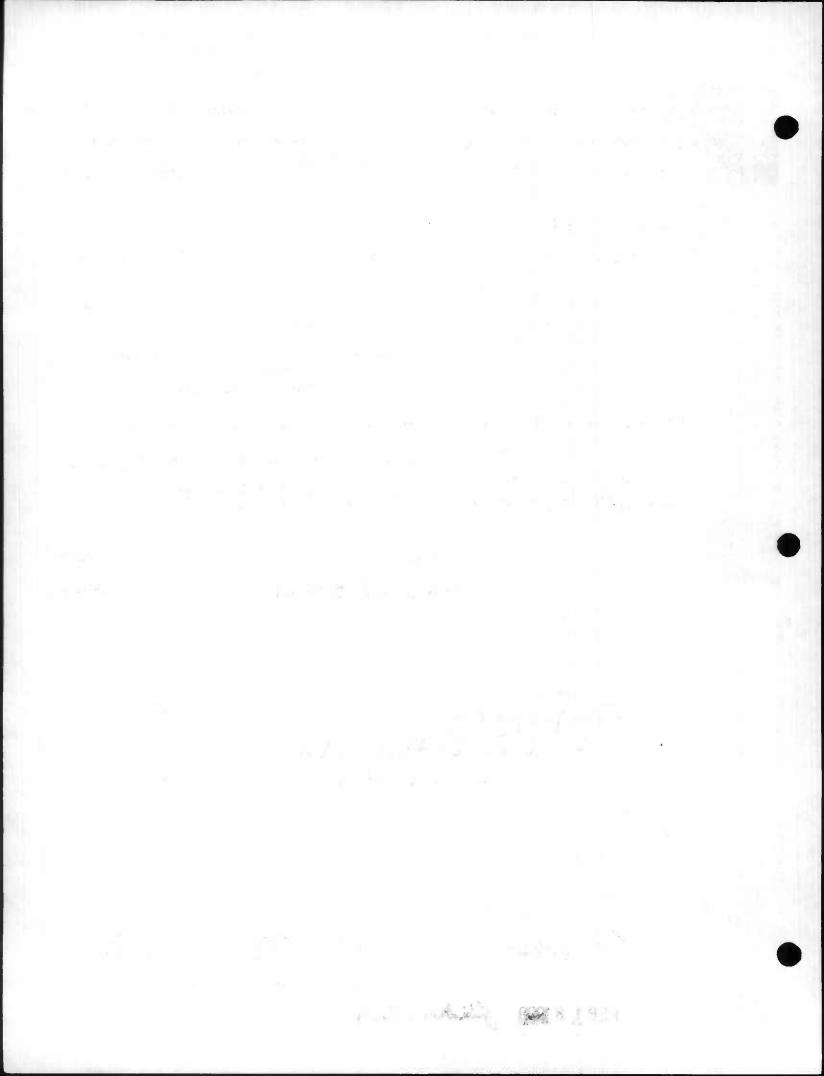
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Phys		1. Decedant's Nema (First, Middle, La	st)			2. Data of D Month	eath	Yaar	3. Time of Death
	ician dical	Beatrice Cha 4a. Facility Nama (If not institution, giv	rlotte Bradu			Februa	ry 17,		9:00 P
	niner				4b. City, Town, o	Location of Dea	th 4c. County	y of Death	
		Ravenwood Luthe			Hagers			ingtor	n
Funer Directe	_	217-10-1770	Sex 7. Age (In yrs. la 1 □ M 2 □ X F 85	Yrs. If Under 1 Yea Months Days		. (Month. D	rth ay, Yaar) 4, 191	9. Birthpl Count 2 Ma	laca (Stata or Foraig stry) nyland
and		Usual Rasidanca of Decedent 10a. Stata 10b. County	10c City	Town or Location					•
Aaryli F sho	2							10	0d. Insida City Limits 1 Yes 2 □ No
the N	Director	Md. Washing	iton Hag	enstown 10f. Zip Coda			40- Ohi		
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er de Item	Funeral	11. Marital Status	12. Was Dacedent Evar in U,S Armed Forcas?	 13. Was Decadant of If Yas, specify Cul 	Hispanic Origin? (ban, Maxican, Pua	Specify Yes or North Rican, atc.)	D- 14. Rad Bla	ca - America ck, Whita, a	
21215-0020 d within 72 hours after giena. w than "natural", or ite	þ	3 ₩ Widowed 4 Divorced	1 ☐ Yas 2 🕅 No If Yas, Giva Year or Datas:	1 ☐ Yas 2 No	Specify:		Specif	y: Wh	ite
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Nore, Maryland 212: ges 1 and 2 should be filed within t of Heelth and Mantal Hygiene. If item 27 is marked other than or other traumatic event, I'm M.		19a. Informant's Name/Ralationship (1		19b. Mailing Addrass (Stream					
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Baltim permit. Pag Depertment Important: I any Injury o	once	21. Signatura of Funeral Service Lican	villiams, Own	22. Neme and Addr gohn T.	ess of Facility William	ns Fune	ral Ho	me	
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Physicia:	n	snock, or haart failure. List only	one ceusa on each line.						Intarval Between Onsat and Death
/Medica	_	Immediate Causa (Finel disaase or condition	ATHEROS	181-710 1	An Amic	1000	n 1 010	D 44 D	21-
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68760 ficate be e physician is the buni	edical	that initiated avants rasulting in death) Last	C. Due to (or a	is a consequanca of):					
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COTGS, P.O. BO) v requires that the death co been signed by the ettend should be detached for us.	Physician/	Part il. Other significant conditions co	ontributing to death but not rasulti	ing in tha undarlying causa gi	ivan in Part I.	23b. Did	tobacco uae co	ntribute to	the cause of death
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Of VITAI RECORDS, Physician: The lew requires the this certificate has been signe trained or an director, page 2 should be or	Be	25. Was casa rafarred to medical axaminar?			28. Place of Da	ath (Check only	ona)		
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	on:	27. Mannar of Death 1 ☑ Natural 5 ☐ Panding	28e. Data of Injury (Month, Day Year)	8b. Tima of 28c. Inju	ry at	28d. Dascribe	how Injury occur	red	
Attending ar death. ector: After by the fune	att	2 Accidant invastigation	1-11/1-		Yas 2□No		NA		
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To the Hospital or At within 24 hours after of To the Funerel Direct complately filled in by	edical	29a. Cartifiar (Check only one) 1 Certifying Phy 2 Medical Exam	raician: To the best of my knowle iner: On the basis of axamination end manner stated.	edga, death occurrad at the ti n and/or investigetion, in my o	ma, data and place opinion, daath occi	a, and dua to tha urred at the tima,	cause(s) and ma data and place,	innar as sta and dua to l	ited. the ceuse(s)
of the of the own	×	29b. Signature and title of certifier		29c. Licans	sa number		29d. Data signe	d (Month, D	av. Year)
- SFO		1 lauren	of hat		28365	-	2.1		
7		30. Name end address of person who b	ompleted cause of death (tra-		-0-00		. ((2. 10	
		Dr. Manzar Shaf			Hanerete	m Md			
	tate	31. Data filad (Month, Day, Year)	MD 368 M1		Hagerstov	ii, rid			
Regis									
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State of Maryland / Department of Health and Mental Hygiene.

					-		tificate of	Death	Re	g. No. 9 8	U	189
16	Physici		1. Decedent's Name (First, Middla, Last) Hazel Rutl		ant				2. Dete of Deeth Month February	Dey	Yeer 998	3. Time of Death 12:30 PM
Y	/Medio		4e. Fecility Neme (If not institution, give s	-				4b. City, Town, or Lo	- d	4c. County		
			Frederick Memorial	Hospita	1			Freder	ick	Fre	deric	k
	Funeral Director		5. Social Security Number 6. Sex 1 1		e (In yrs. last birt	thday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 18	(aar) 3,1921	9. Birthple Counti Mary	ece (State or Foreign y) yland
aryland	show	_	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Towr	or Loc	cation				10	d. Inside City Limits
9 W	F	Director	Maryland Howard		Mt. Ai	ry						1 ☐ Yes 2 No
it.	0.5	Dire	10e. Street end Number				10f. Zip Code		10	g. Citizen of V	Vhet Count	ry?
Ę	238		16381 Camalo Drive				21771			United	d Stat	tes
5-0020 72 hours after death with the Maryland	al', or Items Examiner of	by Funeral	11. Merital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	 Wes Decedent I Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Yeer or Detes: 			Vas Decedent of N Yes, specify Cub ☐ Yes 2 No	Hispenic Orlgin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America ok, White, e	tc.
i i	Hysiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highast grada Elementery/Secondery (0-12)			(Giva I life. D	ent's Usuel Occup kind of work dona NOT use retire	during most of work d)	ing	6b. Kind of Bu	usiness/indu	ustry
D =:	other out	C	17. Fether's Name (First, Middle, Last)				ioinema ke i		e (First, Middla, Mi			
Maryland d 2 should be file	ked c	To Be	John P. Ward Sr.					Myrtle	Olive Wax	ter		
shou	Tan I	-	19e. Informent's Neme/Reletionship (Typ	oe, Print)	19b.	Meilin	g Address (Street	and Number or Rur			Stata, Zip (Coda)
Ind 2	27 is		Faith D. Flester/ I		16	381	Cama lo	Drive, Mt	. Airv. N	larv1ar	nd 217	771
alumore, mit. Peges 1 ar	Depertment of Heelth end Mental Hygiel Important: If Item 27 is marked other than any injury or other traumatic event, in once.		20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Ro 4 ☐ Donetion 5 ☐ Other (Specify)		20b. Place of cematar	Dispos y, cram	ition (Nama of atory or other pla	ce)	Dete 20	Oc. Location -	City or Tow	vn, Stete
Dalli Demit. P	Aportan nportan ny Injur		21. Signeture of Edneral Service Licanse	1/	Meadov	22.	Neme end Addre	rial Park ess of Fecility olesworth				ryland
0.1	1 = 6 0		- ball 17 (Vinen				ge Road,				20872
	ysician Jedical		23e. Pent1. Enter the disease, or complic shock, or heart failure. List only on Immediete Ceuse (Finel	cetions/thet caused e ceuse on each lin	2		,	ng, such es cardiac	or respiratory erres	st,		Approximete Interval Between Onset end Deeth
	aminer	iner	disease or condition resulting in deeth) e.		Due to (or es e		uenca of):	owel			W	seeki
ificate be executed	g physician end es the buriel-trensit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events		Due to (or es a c	consequ						
		n/Medical	thet initiated events resulting in deeth) Last		Due to (or es e c	onsequ	enca of):					
	d for	icia	Part II. Other algnificant conditions conf	ributing to death bu	it not resulting in	theun	derlying cause on	ven in Pert I	23h Did toh	acco use cor	ntribute to	the cause of death
hat the	ned by the ettendir e deteched for use	by Physician/W	Coggu	lopati	<u> </u>		donying cause gr		1 🗆 Yes		3 Probe	
vicion: The law requires that	ss been signed t 2 should be det	Completed b	Acu	te Ren	Tel F			LIP	24e. Wes en performe		avei	re autopsy findings ilable prior to apletion of cause eeth?
T PE	s certificate hes b lirector, pege 2 s	E		te	الحمال ـ	tu	iction		1 ☐ Yea	2 No	10	Yes 2□ No
	rtifica ctor,	Be (25. Was case referred to medical			•		26. Plece of Deet	h (Check only ona,)		
Physician:	47 0	ToE	exeminer?	ospital: 1 Ampatie	nt 2 ER/Out	tpetient	3□ DOA Oti	her: 4 Nursing Ho	me 5 Residen	ce 6 Oth	er (Specify)	
Attending Phys	un. : After this e funeral di		27. Manner of Deeth Naturel 5 Pending 2 Accident Investigation	28e. Dete of Injur (Month, Day	y 28b. T		28c. Inju Wo	ry et rk? Yes 2 \(\subseteq No	28d. Describe how	injury occurr	red	
DIVISION tal or Attending	within 24 hours after deam. To the Funeral Director: After this completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of injubuilding, etc	iry - At home, fai :. (Specify)	rm, stre	et, factory, office	ñ	28f. Location (Stra City or Town,		er or Rural	Routa Number,
To the Hospital or	in 24 nou he Funer pietely fill	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 2 Medical Examination (Check only one)	ician: To the best of ar: On the basis of and menner sta	examinetion end	, deeth 1/or Inv	occurred et the til estigetion, in my	me, dete end plece, opinion, deeth occur	end due to the cau red et the time, dat	ise(s) end me e end plece, e	enner as sta end due to	ited. the cause(s)
Tot	Tot	M	29b. Signature end the of certific	us			29c Licens	f 7537	290	Date signed	Month, D	Pay, Year)
			30. Neme end eddress of persop who cor William H. Johnson	·	,		,	and Man	mourie M		1 217	70
	Sta	ite	31. Dete filed (Month, Day, Year)		y's Signeture	ilge!	LDUALG K	oad , Mon	TUVIA, Ma	тутано	1 41/1	0

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygienes

		Decedent's Name (First, Middle	. Last)		08	rtificate	011	Juan	2 0	Req ate of Death	g. No.		3. Time of Death
Physicia /Medic	-			Binnix						Month	Day 1998	Year	17:50
Examin	_	4e. Facility Name (If not institution	, give street and nur	nber)			4	b. City, Town	or Location	n of Death	4c. County	of Deeth	
		Washington Ad	ventist H	ospita	1			Takoma	Park		Montg	omery	
Funeral Director		5. Social Security Number 218–18–2637	6. Sex 1⊠ M 2□ F	7. Age (In yrs 76	. lest birthday) Yrs.	If Under Months	1 Year Deys		Hrs. 8. D Min. (A Ja1	ate of Birth Nonth, Day, 1	1922	9. Birthpla Country Mary	ce (Stete or Foreign Land
>		Usual Residence of Decedent 10a. State 10b. County		100.0	ity, Town or Lo								
Sa-f sho	ctor	Maryland Montg	omery		lver S							100	1. Inside City Limits 1 ☐ Yes 2 No
23a or 2	al Dire	10e. Streef and Number 1105 Ruatan S	treet			10f. Zip	Code 209	03		109	Citizen of N Ameri		n
el', or items 23a or 28a-f ahow Examiner must be notified at	by Funeral Director	11. Manifei Stafus 1 □ Never Married 25☑ Marrie 3 □ Widowed 4 □ Divorced	If Yes, Giv	rces?		Was Decedif Yes, spec		lispanic Origin an, Mexican, F Specify:	? (Specify) uerto Ricar	res or No- , etc.)	Bia	e - American ck, White, etc. : White	c.
natural',	peted	15. Decedent' (Specify only highes	s Education		16a. Dece	dent's Usua	i Occup	ation	working	16	6b. Kind of B	usiness/Indu	stry
arked other than a	Completed by	Elamantary/Secondary (0-12)	Collega (1	-4or 5+)				during most of			.S. Go		
ther.	ပိ	17. Father's Name (First, Middle, L	ast)		Dis	oursii	ig U	fficie 18. Mother's			rintin eiden Sumen		ıce
marked other than imatic event, the M	To Be			nnix,	Sr.			Eile		urdett		-/	
0 8		19a. informant's Name/Relationsh Jacqueline N. B	nip (Type, Print)		19b. Maiii	•	•	end Number o					oda) and 20903
Important: If item 27 any Injury or other tr once.		20a. Mathod of Disposition 15 Buriai 2 Cremation 4 Donation 5 Other (Sp	3 ☐ Removel from :		Place of Dispo cemetery, cree yds Pre	netory or of	ther plea	n Ceme	tery 2		8 Boyd		
sician edical		23a. Part1. Enter the disease, or shock, or man failura. List of immediate Cause (Final disease or condition	complications that comby one cause on e	eused the dea		26401 ter the mode	Rid:	oleswo ge Roa g, such as ce	d. Dar	nascus	. Marv	land	20872-01 approximate onterval Between onset end Death
miner	ner	resulting in daath)	a		(or as a consec	quence of):	5692		heiter	Ł Neko	Mra	. M	State (/anico
an and rial-transi	Examiner	Sequentially list conditions, if eny, leading to immediate ceusa. Entar Underfying Causa (Disaase or injury that initiated evants	b	Due to	or as a consec	,	7047	//11.	- MAGARET	7 000	71714	·u	wy y OWS
Or (0)	8	Causa (Disaase or injury that initiated evants resulting in death) Last	с	Due to (or as e consec	juenca of):						•	
the attend	Physician/N	Pert ii. Other significant condition	d.	ath but not ra	suiting in the u	nderivina ce	euse giv	en in Part I.		23b. Dld tob	acco usa co	ntributa to t	he causa of death?
	by Phy	Cornrar	y Arkry	Δ.	seare				_	1 🗆 Yee	2 □ No	3 Proba	bly 4 Unknown
2 should	Completed		, ,							24a. Was an performe		avail	autopsy findings able prior to pietion of cause ath?
is certificate he director, page	Con									1 🗆 Yes	2 No	10	Yes 2□ No
certificate rector, pag		25. Was cese rafarrad to medical examiner?							Death (Ch	eck only ona,)		
	္	1 ☐ Yes 200 No	Hospifai:	npatient 2	ER/Outpatier			4 Li Nuisi	ng Home	5 🗆 Residen	ce 6 □Oth	er (Specify)	
		27. Manner of Death	28a. Date of (Mont	of injury h, Day Year)	28b. Time o Injury		Bc. injun	yat k? Yes 2 ⊡ No		Dascribe how	v injury occur	red	
ter th	ation:	1 Natural 5 Pending investig				М	1 🗆						
ter th	ertification:		ot be 28e. Piaca	of injury - At I	home, farm, str ify)				28f. L	ocation (Stre City or Town,	et end Numb Stete)	per or Rural I	Routa Number,
al Director: After thi lled in by tha funeral	edicai Certification:	2 Accidant investig 3 Suicide Could ndatemil 29a. Cartifiar Certifying	ot be 28e. Piaca	ng, efc. (Spec best of my kn	ify) owledga, deatl	reet, factory	, office	na, data and p	iace, and d	city or Town,	Stete) use(s) and ma	annar as stat	ed.

State Registrar

12520 Prosperty
32. Registrar's Signature

20051962

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	1 - FOR STATE REGISTRAR		STATE OF I	MARYL			RTMENT				MENTA	L HYGIEN) ()	1191
	1. DECEDENT'S NAME (First, Mid								BLA		2. DATE	OF DEATH	_	1	3. TIME OF DEATH
	James L	w.	ChAT	-60	200						MONT	'H D/		998	2:15 PM
	4. SOCIAL SECURITY NUMBER	<u> </u>	5. SEX	6. AGE	(In yrs. last i	birthday)	IF UNDER	1 YEAR	IF UNDE	R 24 HRS.		OF BIRTH	2 / /		LACE (State or Foreign
Î	214-10-9730	- 1	1 M 2 F	8	1	YRS.	MONTHS	DAYS	HOURS	MIN.		h, Day, Year)	i	Country)	
	9a. FACILITY NAME (If not institu	ution, give str	4.5		/ 1		9b. CITY.	TOWN	OR LOCATI	ION OF DE		9/16	ac COUN	TY OF DEA	yland
2	Manokix	4	Anor				$\cup \cap \cup$								
DIRECTOR	RESIDENCE OF DECED	DENT	HIOK				FIII	שיים	35	171	nne	<u> </u>	0	m	erset
HE	10e. STATE 10	b. COUNTY				10c. CIT	Y, TOWN O	R LOCA	TION					1	IOd. INSIDE CITY
	Maryland	Wic	comico				Eder	1						1	YES 2 NO
LONERAL	10e. STREET AND NUMBER							10	1. ZIP COD				10g. CITIZ	EN OF WH	IAT COUNTRY?
5	5136 S. Upp	er Fe	erry Rd						21	822				USA	
	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER	N U.S. ARM	ED						N7 (Specify Yea	or No-		- American Indian,
	1 Never Merried 2 Mer 3 Wildowed 4 Divorced		IF YES, GIVE V			,			2 X NO			Rican, etc.)		Specify:	White, etc.
- 4		<u> </u>												Wh	<u>ite</u>
i	15. DECEDE (Specify only hig	nt's EDUC			(Give	kind of	Work done d			ing	160	. KIND OF BUS	SINESS/IND	JSTRY	
COMPLEIED	Elementary/Secondary (0-12)		College (1-4 or 5	+)			,				-	nduetr	ial ('onet	ruction
	17. FATHER'S NAME (First, Middle	4 10		_	wel	Lder							_	OHSC	raccion
- 1										siah		Middle, Maiden	Surname)		
20	Norman G. Ch		ll .												
2	Kathleen L.		am/Wife									ber, City or Town			
	20s. METHOD OF DISPOSITION		Idili/ WITE	_						тту					
	1 St Buriel 2 Cremetion :	3 Remov	val from State	cen	netery, cremi	atory or o	ther place)		ame of		DAT		CATION — C		n, State
	21. SIGHATURE OF EMPERAL SE		odes /	1	Siloa	m Ce		_	ND ADDRE	SE OF EA	2/25	/9¢ S:	iloam	, MD	
	W/ //	./	10/1				F	lol]	Loway	Fun	eral	Home			
_	1011.	·KA	Mour	-				501	Snow	Hil	.1 Rc	.,Sali	sbury	, MD	21804
	23. PART I. Enter the disea shock, or heart	ases, or co t failure. L	implications that lat only one cau	it caution	d the deal	th. Do i	not enter	the mo	de of dy	ing, suc	h as cen	disc or respi	ratory arre	st,	Approximate Interval Batween
İ	IMMEDIATE CAUSE (Final			_				_							Onset and Death
- [disease or condition reaulting in death)		arte DUE TO	ups	cler	ate	e C	als	lio	vas	aut	Par L	uses	re	5 ups
			DUE TO	(OR AS A	A CONSEQU	ENCE O	F):								
5	Sequantially list conditions	b.													
	If any, leading to immediate cause. Enter UNDERLYING	la	DUE TO	(OR AS A	A CONSEOU	ENCE O	F):								
CERTIFICATION	CAUSE (Disease or Injury	C .	DUE TO	(00.40.4	0000000		-								-
	that initiated events resulting in death) LAST		DOE 10	(OH AS A	CONSEQU	ENCE O	r):								
		d.						-							-
	PART II. Other significant of	conditiona	contributing to	death b	out not rac	ulting	In the und	derlyln	g cause	givan in	Part I.	24s, WAS AN	AUTOPSY	24b. W	PERE AUTOPSY FINDINGS
	Multi-	Sufa	rest I	/	rent	ia	. Ca	re	15000	na.	P	PERFOR		c	MAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	Prostale.	Ca	ceison	ca	les	ct	0	_			7	1 TYES 2	A NO	1	F DEATH?
	DID TOBACCO USE			-	OF DEATI	H YE	S N	IO R	1 UNC	ERTAIN	<u>,</u> П			'	YES 2 NO
SICIAN	25. WAS CASE REFERRED TO ME						TH (Check o		2 0110	EKIAII	•				
	EXAMINER? 1 YES 2 NO		HOSPITAL: 1 Inpatient 2	ER/Outp	patient 3	DOA	OTHER		10 5 □ Re	asidanca	6 Oth	e (Specific)			
	27. MANNER OF DEATH		26s. DATE OF	INJURY		26b. TIM	E OF	28c. INJ	URY AT			CRIBE HOW IF	JURY OCC	JRED	
	1 Netural 5 Penc	ding stigation	(Month, D	ay, Year)		INJ	URY M		YES 2	NO					
	2 Accident Invest	-	26s. PLACE O	F INJURY	— At home	e, lerm, r	street, facto	ry, offic	•		261. LOC	ATION (Street a	nd Number o	r Rural Rou	ite Number,
		rmined	boliding,	etc. (Spec	ciry)						City	or Town, State)			
u n	29e. CERTIFIER 1 X CERTIFYII	ING PHYSICI	IAN: To the best of	my know	rledge, deat	h occure	ed at the tie	ne, det-	and place	and due	to the co-	(20(0) 0-4	mer en mini-	4	
COMPL															and mariner as stated.
- 11	29b. SIGNATURE AND TITLE OF											1			
	Megan	1	Boll	2.	∇	7	>			ENSE NUN 295		_			Nonth, Day, Year) 3 - 98
2	30. NAME AND ADDRESS OF PER	RSON WHO	COMPLETED CALL	SE OF DE	ATH (ITEM	27) (Fine	Print)		200	- 1)			- 1	7.	7-18
- II															

LLOSO, M.D.: 5302 CHINABERRY DRIVE, SALISBURY MD Y & REGISTRAR'S SIGNAULE, LA D'AUGUST NAMELL

M. BELL

25 1998

GREGORIO

John Polling SS# 221-12-5018

Physicia	_	1. Decedent's Ne										2. Dete of D Month	Dey	0	Year	3. Time of Dee
/Medic		JONN EV 4a Fecility Neme				her)				lb. City. Toy	vn, or Lo	Feb Vu	ary /		of Deeth	2019
Examin	er		ULA REC				NTER				LISB			COM		
uneral irector		5. Sociel Security 221-12-		6. Sex	M 2□ F	7. Age (In yrs.	. lest birthdey) Yrs.	Months Months	er 1 Year Deys	If Under 2 Hours	24 Hrs. Min.	8. Date of E (Month, 1 1-26-1	Birth Dey, Year) 1919		9. Birthple Countr	DE •
3_	-	Usuel Residence 10e. State	of Decedent 10b. Coun	ntv		10c. C	ity. Town or Lo	ocation							10	d. Inside City Lir
important: if lean 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Medical Examiner must be notified at once.		De.		sex			elmar									Y Yes 2□
r 28a	rec	10e. Street and N		SCA			CIMUI	10f. Z	ip Code				10g. Citiz	en of W	/het Counti	ry?
238	alD	500 Del	aware	Ave.					1994	0			US	SA		
A STATE OF THE STA	by Funeral Director		s arried 2.2XM 1 4. □ Divorc	erried	12. Wes Dece Armed For 1 XYes If Yes, Give Year or De	ces?			edent of Hecify Cuba	ispenic Orig an, Mexicen Specify:	gin? (Spe , Puerto	ecify Yes or I Rican, etc.)			e - America k, White, e	tc.
	ted	40-	15. Deced	ent's Educ	cation	72. 7	16e. Dece	dent's Usi	uel Occup	etion	ad marki		16b. Kin	nd of Bu	siness/Indu	
	Completed	Elementery/Se	ecify only high econdary (0-12	2)	College (1-	-4or 5+)		mobi		dunin <i>g m</i> ost ealer	or works	ng	Deal	lers	hip	
	Be	17. Fether's Nem										(First, Midd				
	2	E. Fran										Mess:				
		19e. Informent'a										nar, De			Stete, Zip (Code)
	-	Agnes M		TIRS,	, wile	20b.	Plece of Disponentery, cre				DeTI	Dete	_		City or Tow	vn, Stata
		4 Donetion	2 Cremetion 5 Other	(Specify)		SIEIE	. Step	hens	Ceme	tery		-22-98	B Del	Lmar	, De.	
once.		21. Signature of	Funerel Service	ce License	-41		2	Shor	t Fur	ss of Fecility teral	Home	, Inc				
_		shock, or h	eart fellure. L	ist only on		ech line.	th. Do not en	ter the mo	ode of dyin	ig, such es	cardiec d		errest,	1994		Approximete Intervel Betweer Onset end Deet
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cal	Be Completed by Physician/Medical	shock, or h Immediate Ceus disease or condi resulting in deell Sequentielly list if eny, leeding to ceuse. Enter Uncuese (Disease thet initiated eve- resulting in deeth	eart feiture. L le (Fine) fition h) conditions, immediate dertying or injury nts h) Lest	tions con	. Pro-	Due to (or es e conse	quence of	es Pi): ceuse giv	eg, such es la contra del contra de la contra del la	cardiec c	23b. Di	d tobacco	wee cor	atribute to 3 Prob	the cause of de ably 4 Unk re autopsy findin ileble prior to apletion of cause eeth?
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Georgia A. Collins 1130 A.M 4b. City, Town, or Location of Death 4c. County of Death 19 4a Facility Name (If not institution, give streat and number) PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5. Social Security Number If Under 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 KF Months Days Hours Min 91 221-50-8052 4/26/1906 Delaware Usual Residence of Decedant 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Millsboro 1 Yas 2 No Delaware Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19966 Rt. 3 Box W28 USA 14. Rece - American Indian. 11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Giva kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) homemaker homemaking 18. Mother's Name (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Mary Ann Betts Levin Daisey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Rt. 10 Box 45, Millsboro, Delaware 19966 Betty A. Rust 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 2/22/98 Willards, Md. Bethel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Watson Funeral Home, Millsboro, Del. 19966 alson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat end Deeth 10 slows Immediate Cause (Final disease or condition resulting In death) Sports Myverrelise sequence of): Due to (or as a consequenca of) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy wanted Age 1 Yes 2 No 1 Yes 2 No

Physician /Medical Examiner

Physician

· /Medical

Examiner

Funeral

Director

r 28a-f show

7 is marked other than "natural", or items 23a or itemmatic event, the Medical Examiner must be r

permit. Pages 1 and 2 should be filed within 72 hours eftar on Department of Haaith end Mental Hygiene.
Important: If them 27 is marked and injury or other and injury

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Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in daath) Last physician the buriel Physician/Medical usa as signed by the e

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Certification:

Medical

29b. Signature and title of certifier

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After

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24 hours a Funerel D

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yaar) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

way

29c. License number

29d. Date signed (Month, Day, Year)

DRIVE, SISISTY, MD 21804

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Rrint)

1104 31. Date filed (Month, Day, Year)

FEB 231998

32. Registrar's Signature J. Di Stevideon Rardall

Registrar

State



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time Death Month **Physician** 1230 Esther T. Cummins 1998 16 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner | SALISBURY | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | 11-18-1906 PENINSULA REGIONAL MEDICAL CENTER WICOMICO if Under 1 Year 5. Social Security Number 9. Birthplace (Stete or Foreign Country)
Ark. 7. Age (In yrs. lest birthdey) **Funeral** Months Deys 1□M 2⊠F 91 Vre 218-20-7728 Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Md. Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 27972 Waller Rd. USA 21801 Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marltel Status 14. Race - American Indian, Black, White, etc. filed within 72 hours efter Hygiena. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by White 3X Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 2 should be fill end Mantel H Be P Jeptha Paterson Rhoda French Patterson permit. Pages 1 and 2 shr Depertment of Health end Important: If item 27 is mi any injury or other traums 2002e. 19a. informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Luther F. Cummins, Jr. 29282 Waller Rd. Delmar, Md. 21875 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stete Buriai 2 Cremetion 3 Removal from State 4 □ Donation 5 □ Other (Specify) Parsons Cemetery 2-19-98 Salisbury, Md. 21. Signature of Funeral Sarvice Licansee 22. Name and Address of Facility Hoely Short- Hannigan Short Funeral Home 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one causa on each lina. 13 E. Grove St. Delmar, De. 19940 Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Colon Cancer nonth Examiner Due to (or as a consequenca of): Examiner physician and the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): They (LUMMIN) S Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequenca of): 80 attending esn Po Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the s 23b. Did tobacco use contributa to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed peen s paga 2 has 1 ☐ Yes 2 No certificata or Attending Physician: Be 25. Was casa rafarred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Certification: To Impatient 2 ER/Outpatient 3 DOA of this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division After 1 Natural 2 Accident 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation after deeth Director: 6 Could not be detarmined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital Cartifying Phyeician: To the best of my knowledga, daath occurred at the time, dete and piece, and due to the cause(s) end manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred et tha time, data and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Dey, Year) 029105 redeal

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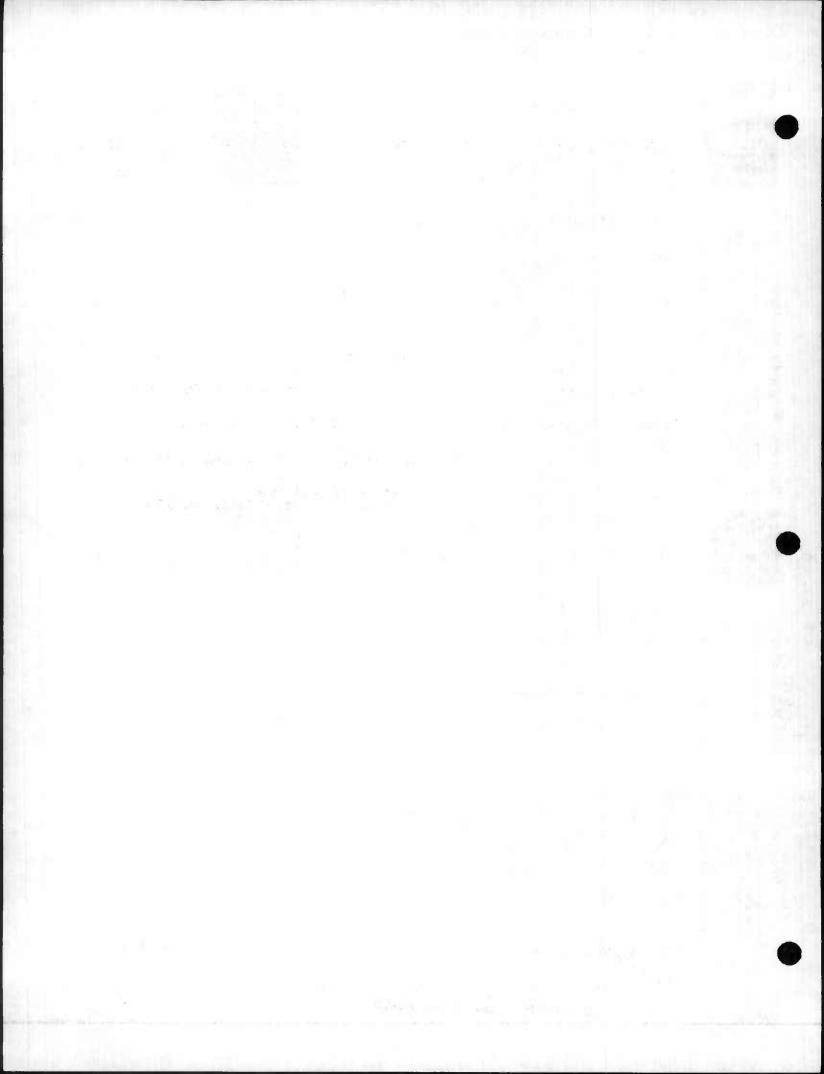
State Registrar 31. Data filed (Mont)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 9 1998

Auddleston

M.D



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Neme (First, Middla, Last) 2. Deta of Death 3. Time of Deeth **Physician** Month Raymond Dayle Cluck 24, 1998 FEBRUARY 2:55 AM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner PHYSICIANS MEMORIAL HOSPITAL CHARLES LAPLATA 5. Sociel Sacurity Number If Undar 1 Year If Undar 24 Hrs Hours Min. 8. Date of Birth Oct. 9. Birthplece (State or Foreign T6 Beffeville, IL 7. Age (In yrs. last birthday) **Funeral** Deys 1⊠M 2□ F 704-07-8267 81 Director Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic avent, the Medical Examiner must be notified at Director 1 ☐ Yas 2 No Calvert Dunkirk 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6330 Northbrook Dr. 20754 U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? ↑ 1 Yas 2 □ No If Yes, Give Yaar or Detes: 14. Race - Amarican Indien, Bleck, Whita, etc. Wes Dacedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Marriad 2 Married 1□ Yes 2₽No White à Widowed 4 □ Divorced Completed 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) Service Tavern Owner 17. Fethar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be Raymond Cluck Edith Redfern To 19e. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code) Important: If tem 27 is any injury or other trainingness. Janice Gielda/Daughter 6330 Northbrook Dr. Dunkirk, MD.20754 20e. Method of Disposition
1 ABuriel 2 □ Cremetion 3 □ Ramovel from State 20b. Place of Disposition (Name of cemetery, cramatory or other place)

Lakeview Mem. Gardens 2/28/98 20c. Location - City or Town, Stete Belleville, IL. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee 22. Nama and Address of Fecility Arehart-Echols Funeral Home, P.A. M00945 P.O. Box 567 La Plata, MD 20646 23a. Part1. Enter the disease, or compilcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximeta interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) 1 LURE Examiner Examiner Sequentielly list conditions, if eny, leading to immediate causa. Enter Underlying Ceuse (Disaase or Injury thet initieted evants resulting in death) Last Due to (or es e consaguence of) Physician/Medical Dua to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown þ 24a. Was en eutopsy performed? Be Completed 24b. Wera eutopsy findings available prior to completion of causa of deeth? 1 🗆 Yas 2 2000 1 ☐ Yes 2 ☐ No 25. Wes case rafarred to medical axeminer? 26. Plece of Deeth (Check only one) Hospital: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) P 27. Menner of Death 28c. Injury at Work? 28e. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Aaturai 1 Yes 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide in by t 28e. Piece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et tha time, dete end piece, end due to tha ceuse(s) end menner es steted.
2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et tha tima, date and piece, end due to the causa(s) end manner steted. Medical 29a. Certifier completaly (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Dete signed (Month, Day, Year) 999 0100 a D-44436 and address of person who completed cause of death (Itam 23a) (Type, Print) ASHVIN J. PATEL M.D. PRESTON SQUARE 2 6B INDUSTRIAL PARK DRIVE WALDORF MD. 20602 31. Data filed (Month, Day, Year) 32. Registrer's Signature State FEB 2 5 1998

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Pages 1 and 2 should be fant of Health end Mental

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ettending physician

certificate

Aftar this

or Attending Physician:

the Hospital within 24 hours e To the Funeral C

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Division of Vital Records, P.O. Box 68760.

Baltimore.

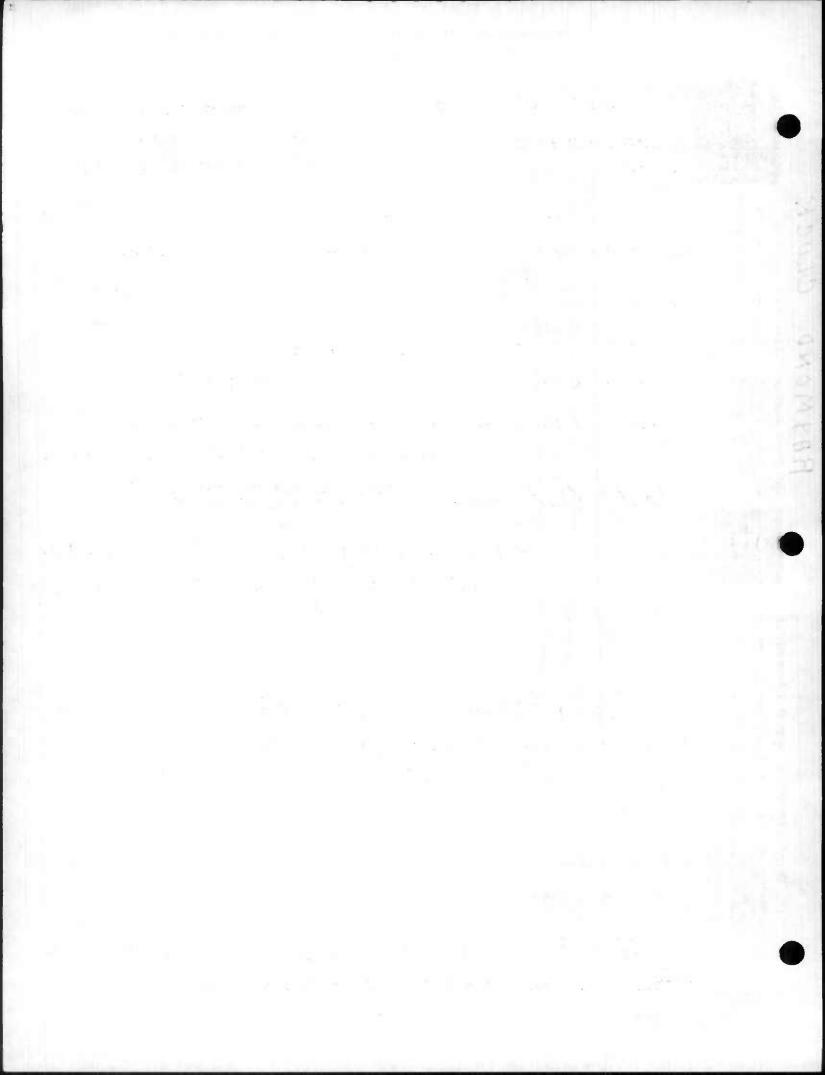
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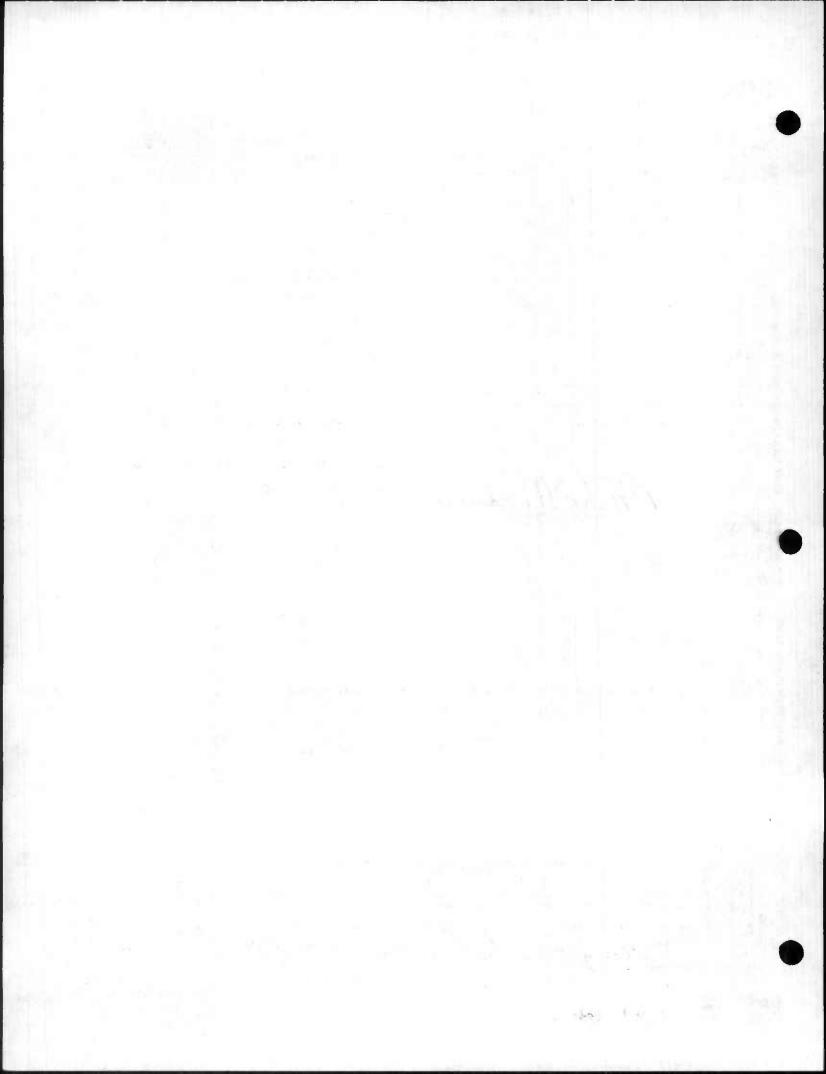
or Items 23a



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 96 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Day ELVA REGINA DAVIS /Medical FEB 24 1998 4:50 P.M. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16804 OLD NATIONAL PIKE, SW FROSTBURG ALLEGANY If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funerai** 8. Date of Birth (Month, Day, Year) Days Months 1□M 2☑F Yrs. Director 219 44 0198 95 DEC 1 1902 MARYLAND Usual Residence of Decedent death with the Marylend 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 10d. Inside City Limits MARYLAND ALLEGANY Director FROSTBURG 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16804 OLD NATIONAL PIKE, SW Funeral 21532 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, While, etc. permit. Pages 1 and 2 should be filed within 72 hours efter to Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural; or ites any injury or other traumatic event, Ita Medical Engine 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dales: Maryland 21215-0020 1 ☐ Yes 2√ No 2 Specify: WHITE 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 2 WILLIAM F. MICHAELS NORA E. RARICK 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNA MARY KENNEY /SISTER 16804 OLD NATIONAL PIKE, SW, FROSTBURG, MD 21532 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. MICHAEL'S CEMETERY 2/26/98 FROSTBURG, MD 21532 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. Sowers 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medicai immediate Cause (Final Mukrown disease or condition resulting in death) Examiner Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last and Due to (or as e consequence of) buriel P.O. Box 68760. physician Physician/Medicai the Due to (or as e consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. thed 23b. Did tobacco use contributs to the cause of death? signed by Demente 1 Yes 2 No 3 Probably 4 Unknown Records, à Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? peed ate hes certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director; Be 25. Was cese referred to medicel examiner? 28. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5₽ Residence 6 □ Other (Specify) Certification: To 1 ☐ Yes 2 110 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending 1 Natural 2 Accident Investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner as stated.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) To the 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) burg mpleted cause of death (Hem 23a) (Type, Print) 30. Neme and address of pe 917 Seton De Cumbreland MD YW 32. Registrar's Signeture (homas 31. Date filed (Month, Day, Year) State FEB \$ 6 1998 Registrar

DHMH 16 Rev 6/95



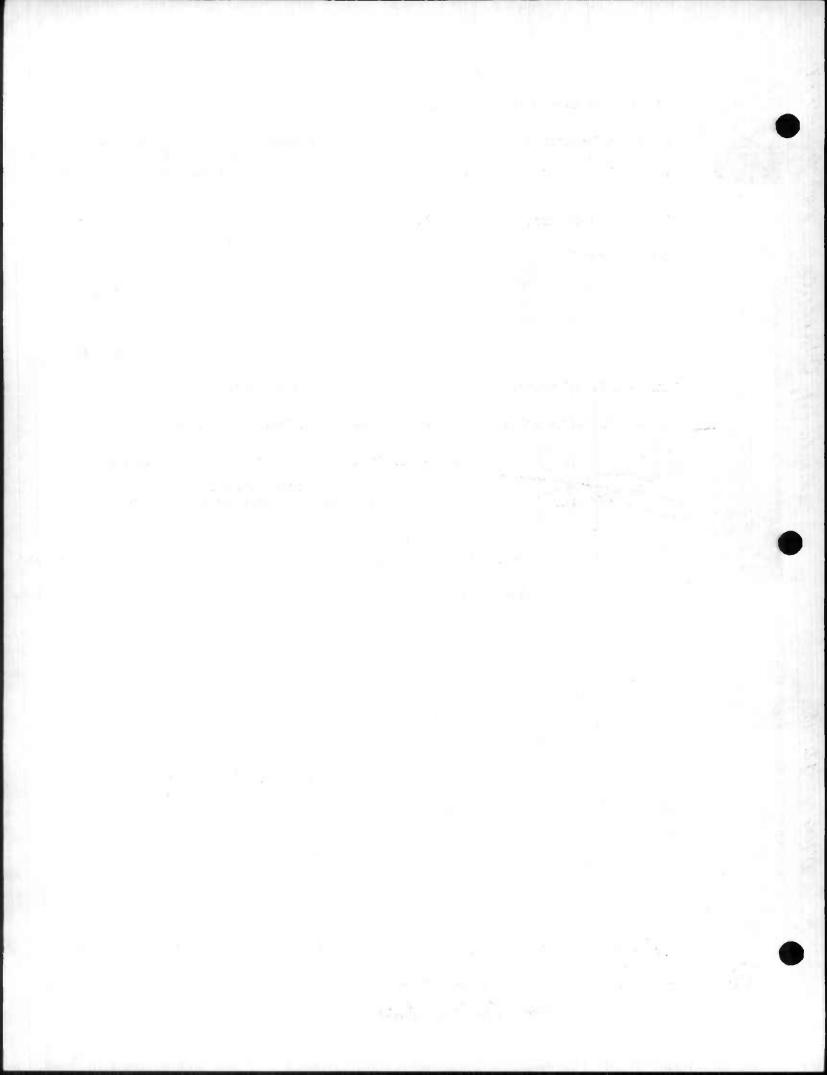
Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Month Clarence Vincent DeLancey, Jr. 0730 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Days Hours 57 Yrs. Director 261-50-6479 Florida Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Experient must be notified at Director 1X Yes 2 No Worcester Berlin the 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 10602 Flower St. 21811 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: b 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Depertment of Heelth and Mental Hyglene. Important: if item 27 is marked other than "n any Injury or other traumate according to the contract of the contract Elementary/Secondery (0-12) College (1-4or 5+) Waiter Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Clarence V. DeLancey, Sr. Georgia Adams elancey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. DeLancey/wife 10602 Flower St., Berlin, MD 21811 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriai 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) St. Pauls Cemetery 2/28/98 Berlin, MD 22. Name and Addrass of Facility
Lewis N. Watson Funeral Home 21. Signature of Furniral Septice Licensea. 1618 West Rd., Salisbury, MD 21801 2011 Part Enter the disaasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final a KUPTURED disease or condition resulting in deeth) AURTIC ANEURYSM Examiner Physician/Medical Examiner physiclen and the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760. Due to (or as a consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown à 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No Vital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No Certification: To Division of After this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Metural 1 ☐ Yes 2 ☐ No 2 Accident efter deeti 6 Could not be determined 3 ☐ Suicide Placa of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e To the Funaral D completely filled edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifiar 29c. License number 29d. Date signed (Month, Day, Year)

203 SNOW ST. SNOW HILL MD. 21763

State Registrar 31. Date filed (Month, Day, Year) FEB 2 4 1998 Julia Shurler Rardell

30. Name and address of person who compreted cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death 19, 1998 5:30 AM February Mary A. Driskill 4a. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 7. Aga (In yrs. last birthday) If Undar 1 Yaar 5 Social Security Number If Undar 24 Hrs. 6. Sax 8. Data of Birth (Month, Day, Year) Aug. 5, 1924 9. Birthplaca (State or Foreign Country) New York 1□M 2⊠F Days Yrs. 73 578-20-6553 Usuat Rasidanca of Decedan 10h Counts 10c, City, Town or Location 10d. Inside City Limits 1 Yas 25 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 20872 28421 Honeysuckle Drive American 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2√2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacadant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry County Elamentary/Secondery (0-12) Collaga (1-4or 5+) School System 12 Secretary 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) John Antoniow Xenia Kijak 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda A. Riggs - Daughter 13050 Penn Shop Road, Mount Airy, Maryland 21771 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burlal 2 □ Cramation 3 □ Ramoval from Stata Gate of Heaven Cemetery 2/23/98 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licansee 22. Nama and Addrass of Facility Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Approximata Interval Batween Onsat and Death

Physician /Medical Examiner

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page 2

certificete

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, i

To the Hospital o within 24 hours aff To the Funeral DI completely filled in

Physician/Medicai

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Completed

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Medical Certification: To

The law requires that the death certificate be executed

Box 68760,

P.O. I

Records,

Division of Vital

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death

72 hours after

Baltimore, Maryland 21215-0020

Director

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Completed

7 is marked other than "natural, or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Maging Once.

Sequantially list conditions, if any, laading to immedieta cause. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in deeth) Lest

25. Was case rafarrad to medical axaminar?

29b. Signatura and titla of con

1 Natural

Immediata Causa (Final disaesa or condition rasulting in daath)

Dua to (or es/a

Dua to (or as a consequanca of) 23b. Did tobacco usa contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to complation of causa of death?

2 0 No

26. Piaca of Daath (Check only one)

Othar: 4 Nursing Home 5 Residence 6 Othar (Specify)

1 Yes 2 No 1 Dingatiant 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Panding investigation 1 Yes 2 No

2 Accident 3 ☐ Suicida 8 Could not be determined 28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 Homicide

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Cartifian

Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceusa(s) and manner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated.

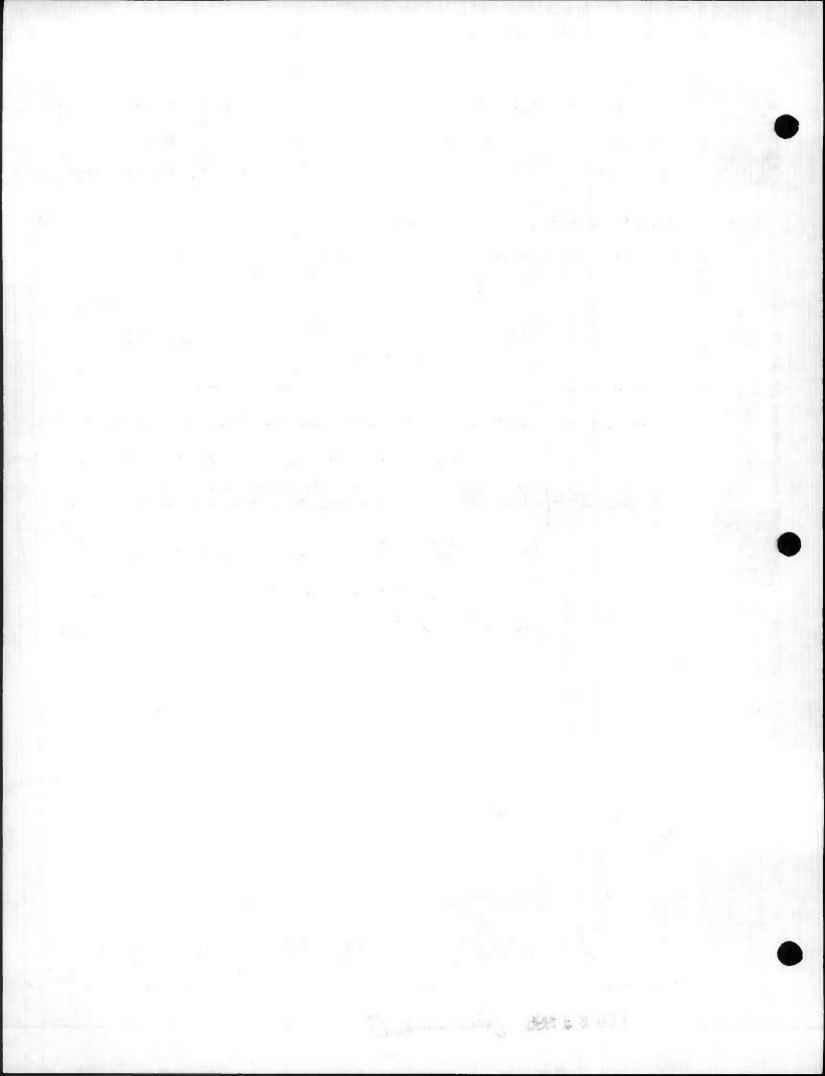
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cause of death (Item 23e) (Type, Print) 30 Nema and addrass of person

Philip Dr. Olray, toD 1/100 31. Data filad (Month, Day, Year) 32. Ragistrar's Signatura

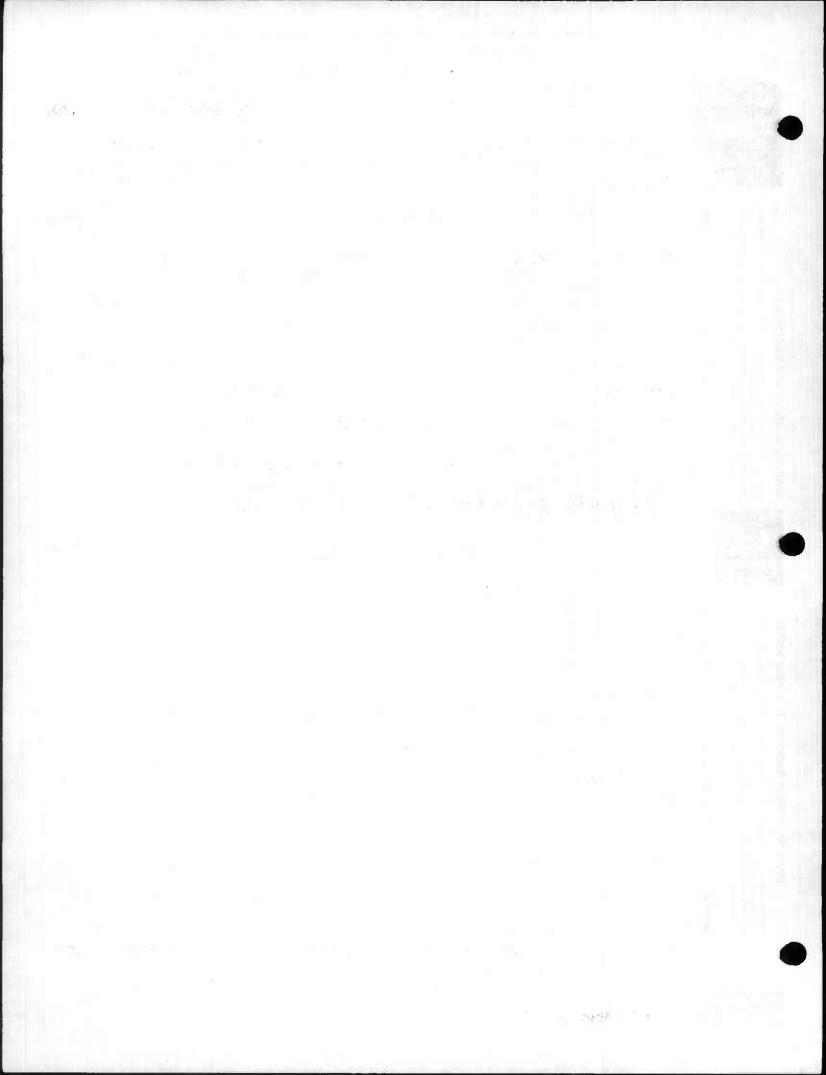
State Registrar





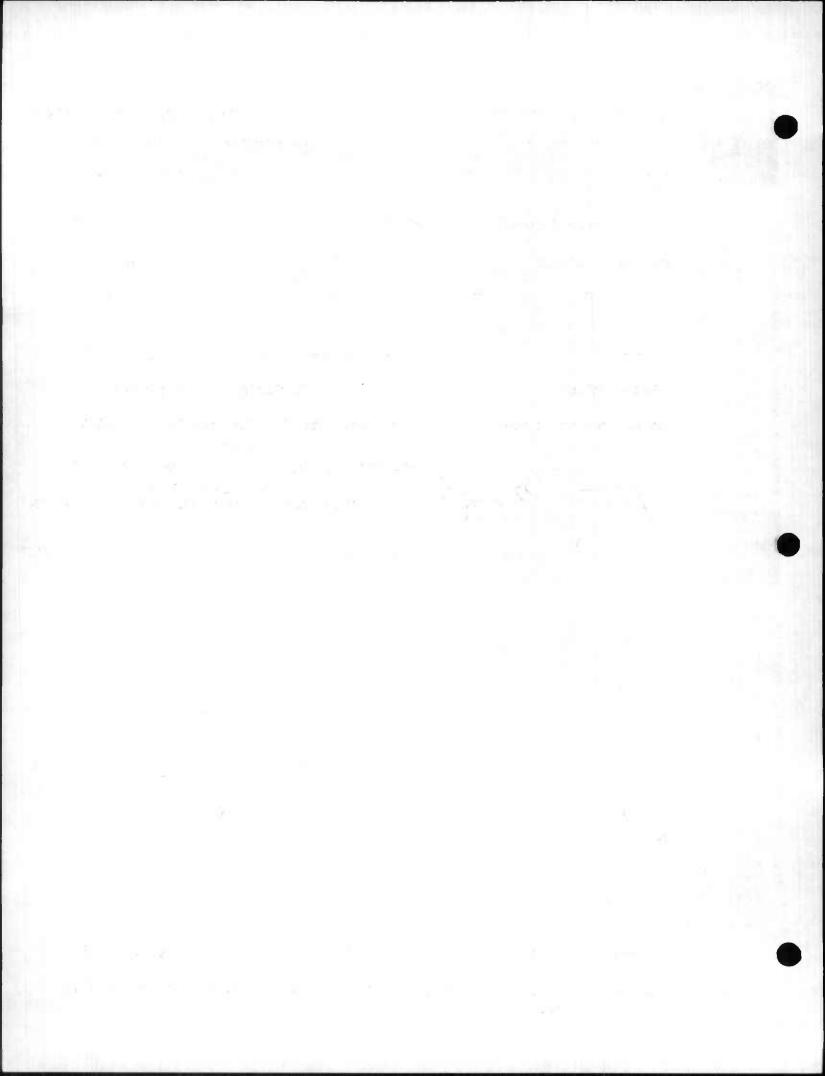
State of Maryland / Department of Health and Mental Hygiene

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	or 28	Dire	10e. Street and Number				10f. Zip Coda		10	g. Citizen ot W	hat Countr	y?
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Baltimore,	of Health of Health litem 27 r other tr		20a. Method of Disposition YE Burlal 2 Cramation 3 F		20b. Place	of Dispos	sition (Nama of natory or other pla			Oc. Location - C	City or Tow	m, Stata
Ē	Pag ment ant: H ury o		4 □ Donation 5 □ Othar (Specify)	amoval from Stata	VALE	SUMM	IT CEMET	ERY 2	/28/98 V	ALE SUM	MTT.	MD
Balt	permit, Pages 1 and Depertment of Health Important: if Item 27 any Injury or other tr Once.		21. Signature of Funeral Service License	$m \Lambda$	1	22. S	Nama and Addr OWERS FL	ess of Facility JNERAL HOI	ME, P.A.			_
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State of Maryland / Department of Health and Mental Hygiene 8 0 7 2 0

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within 72 hours effer death with the Maryland lene. than "natural", or tems 23a or 28a-f show the Modical Examinal must be notified.			rried 2 Married	If Yes, G	2/21/No		1 🗆 Yes	_	Specify:		Specifi		
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Physic /Medic		Victoria	Ame	rica	FO	LAND)	Februar	y 18, 1	rą ą 8	7:40 P.M.
Examir		4e. Facility Name (If not institution, give Citizens Nursin		Frederi	ick Cour		4b. City, Town, or L Fre	ocation of Death	4c. County	of Deeth	Frederick
Funeral Director		Social Security Number 6. Security Number		(In yrs. lest bir		r 1 Yeer	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey Jan. 3,	Yaer) 1919		oleca (Stete or Foreign orty)
pue *		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Tow	or Location						Od. inside City Limits
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th with t	Funeral Director	10e. Street end Number 203 West Green St	treet		10f. Z	p Code	21769)	0g. Citizan of	What Coul	
and ZIZIS-UOZU be filed within 72 hours efter deeth with the Maryland ttal hygiena. d other than "natural", or items 23s or 28s-f show event, fre Medical Elegin est must be modified.	þ	11. Maritel Stetus 1 Naver Merried 2 Married 3 Naver Merried 4 Divorced	12. Wes Decedent E Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Giva Yeer or Detes:		13. Was Dace If Yes, sp		dispenic Orlgin? (St en, Maxican, Puart Specify:	pecify Yas or No- Rican, etc.)		ck, White,	ean Indian, etc. nite
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	-	19e. Informent's Neme/Relationship (7) Janice Capino/I		19b 43	Meiling Address	s (Street spar	end Number or Ru Road, Mi	rel Route Number	City or Town	, Stete, Zip 1769	Code)
Datumore, M permit. Pages 1 and 2 Depertment of Heelth Important: If Item 27 I any Injury or other tra once.		20e. Method of Disposition Disposition Cremetion 3 1 4 Donetion 5 Other (Specify,		cemeter	Disposition (No. 1), cremetory or Ven Merr	othar plac	1 Gardens		20c. Location L, 1998		own, Stete derick, MD
permit. Pag Depertment Important: I any Injury o		21. Signature of Funeral Servica Licens		M00021	Keene	y &	ss of Fecility Basford Church S			ck, M	D 21701
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oet tha d d by the detached	by Physician/M	Part II. Other significant conditions co	ntributing to death but	A	the underlying	1	ren in Pert 1.	`	es 2 No		the cause of death?
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To the Hospital or Att within 24 hours after d To the Funeral Direct complately filled in by	edicai	29a. Certifier (Check only one) 1 Cartifying Phy 2 Medical Exami	eicfan: To the best of ner: On the basis of e end menner stete	examinetion end	, death occurred l/or Investigation	et the tin	ne, dete end plece, plnion, death occur	end due to the c red et the time, d	ause(s) and m ete end plece,	enner es s end due te	tated. o the cause(s)
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		CLEAN TOWAR	54)	-4h //h - 5.2 : :		D475	556	C	2/19/98	5	
		30. Name and address of person who of William Johnson				on D	rive, Fre	ederick,	MD 217	702	
Sta Registr		31. Dete filed (Month, Dey, Year)	32. Registrer				EED O A	1000	Jalia Da	ر الم	P
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State of Maryland / Department of Health and Mental Hygiene 98 07202

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/Medic		Aldyth Emily He	ager								February	De	23	1998	11:30 P	M
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Funeral Director		5. Social Sacurity Numbar 213-10-5264	6. Sa	ax □M2∑xF	7. Aga (In yr. 84	s. <i>last birthda</i> Yrs.	y) If Unda Months			Min.	8. Data of Bird (Month, De 06-Jun-)		placa (Stata o	or Forai
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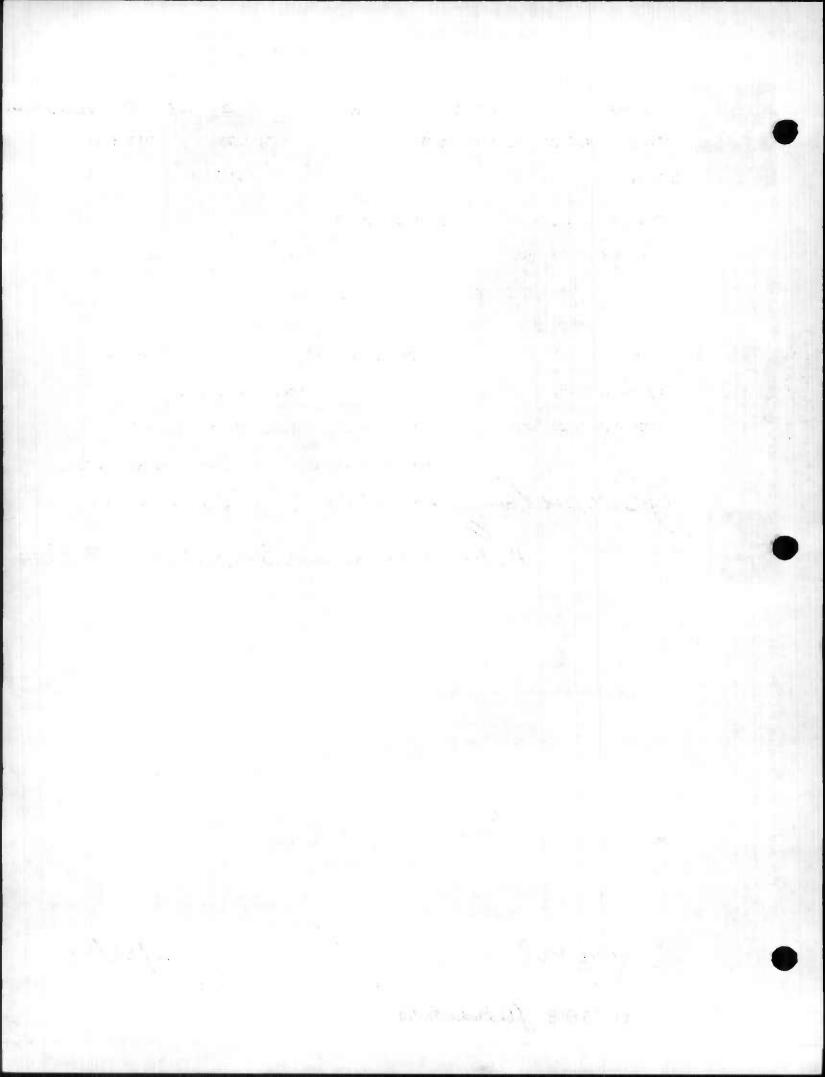
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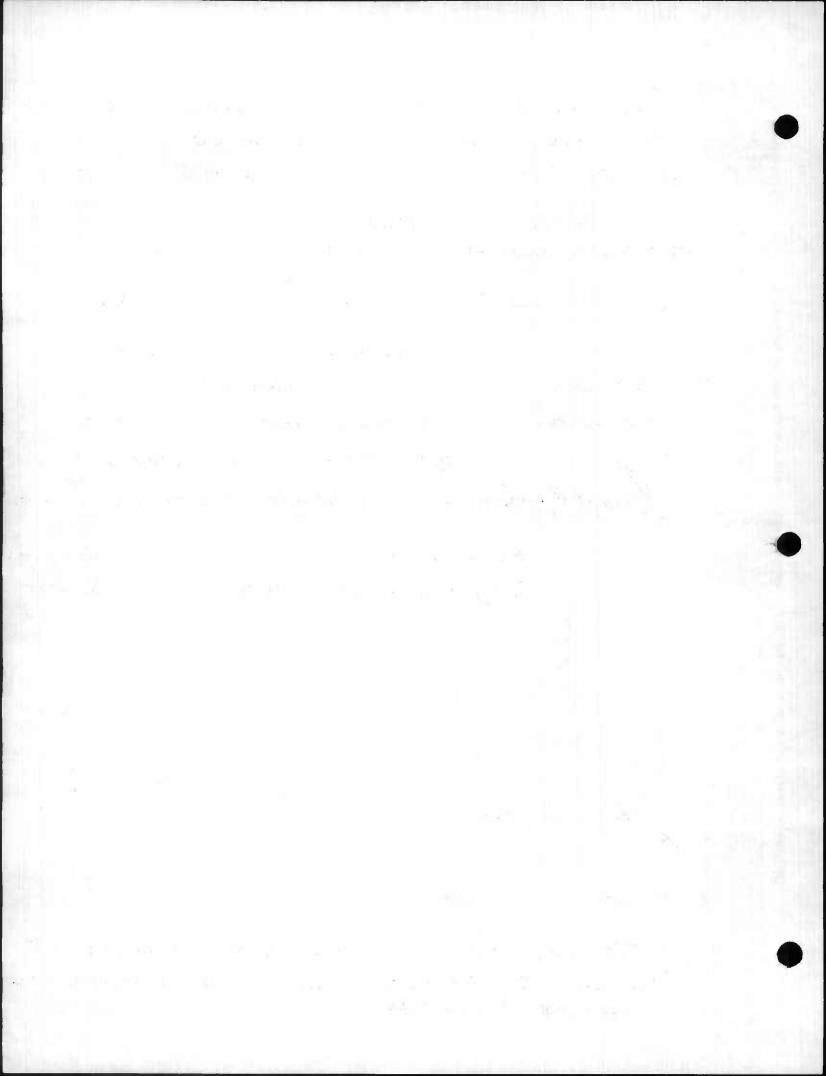
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Virector: Aftar this cartificate has been signed by the ettendir in by the funaral director, page 2 should be deteched for usa	edical Certification: To Be Completed by Physician/M	Sequentially list or if any, laading to in ceuse. Enter Undi Causa (Disaasa or thet initiated avant rasulting in daath) Part II. Other algnit 25. Was cesa referaxaminar? 1 Yes 2 27. Mennar of Deat 1 Natural 2 Accident 3 Sulcide 4 Homloida 29a. Certifiar (Check only one) 29b. Signature and	ficant conditions of the state	d	Due to of Due to of Injury h, Day Year) Dest of Injury - At ng, atc. (Spacebast of my knists of examination of the property o	Cor as a consection as a conse	quance of): quanca of): quanc	given in Part I. 26. Place of Dae Other: 4 \(\text{Nursing H} \) njury at Vork? \(\text{Yas} 2 \(\text{No} \) ce	23b. Did 1	Yes 2 No s an autopsy primed? Yas 2 No one) Idance 6 O how injury occi Street and Num win, Stata)	3 Proba 24b. Wat avair corror of d 1 U thar (Specify, urred	ra autopsy findinieble prior to plation of ceuse eath? Yas 2 No Routa Number,



96-0674-021 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene MICHAEL JAMES Certificate of Death HANDREN 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Month FEBRUARY 11, 1998 **Physician** Michael James Handren 4:55 PM /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** BRUNSWICK FREDERICK 302 PETERSVILLE ROAD If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) Funeral XXXM 2 F Months Days Hours Min 385-40-2564 Yrs. Dec 19 1940 Michigan Director Usual Rasidance of Decedant 10c. City, Town or Location 10a Stata 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic svent, the Medical Examinar must be notified at MD 1 XYes 2 No Frederick Brunswick Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? USA 1050 Onndorff Court 21716 Funeral death permit. Peges 1 and 2 should be filed within 72 hours effer deal Department of Health and Mental Hygiene. Important: If them 27 is marked other them. 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Orlgln? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Ricen, etc.) 14. Race - American Indian. 11. Maritel Status 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) VA Dept of Transp. Collaga (1-4or 5+) Elamantary/Secondary (0-12) Leesburg, Surveyor 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) Frederick Carlton Handren Loris Finton 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1050 Orndorff Ct. Brunswick MD 21716 Aloma Handren (Wife) 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, cramatory or other piece) Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 € Cramation 3 ☐ Ramoval from Stata Hagerstown Crematory Hagerstown, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funcial Service Ligarsee Banbana A. Williams, 22. Name and Address of Facility
John 1. Williams Funeral Home
Owner 100 Petersville Rd Brunswick MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onsat and Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in death) Hend Injuries Examiner Dua to (or as a consequence of) Examiner physician end the buriel-trans Sequentially list conditions, if any, leading to Immediata cause. Enter Underfying Cause (Disease or injury that hitteled events resulting in death) Lest Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequance of): 80 use 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wara autopsy findings available prior to 24a. Was en autopsy performed? Completed complation of causa of death? 19Yas 2□No 1 9 Yas 2 No Attending Physician: Be 25. Was casa rafarrad to medical examinar? 26. Placa of Death (Check only ona) Yas 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 MOther (Specify) SCENE Certification: To funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how tnjury occurred 28c. Injury at Work? 5 Pending invastigation 1 Natural 2-11-98 4 54 PM 1 ☐ Yas 2 Ø No Dove - auto-truck callisun To the Hospital or Attendi within 24 hours effer deeth To the Funeral Director: A 2 Accident 6 Could not be datarmined 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State)
302 Perers Ville Road 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida Roadway 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Cartifiar

Registrar

31. Dete filed (Month, Day, Year)

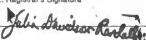
David

29b. Signatura and title of certifier

(Check only one)

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

O a control of the contro 32. Ragistrar's Signatura



29c. License number

OCME

29d. Data signed (Month, Day, Year) FEBRUARY 12, 1998

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

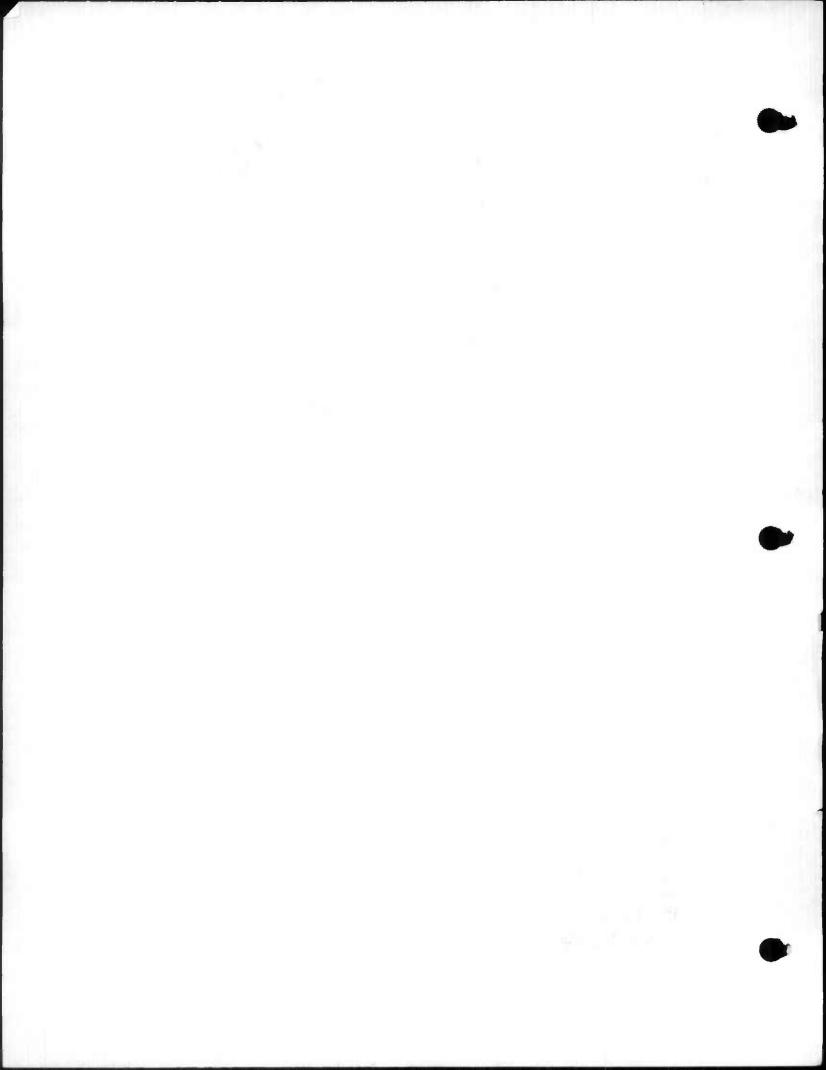
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be neitfied at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE OF DE	EATH		3. TIME OF DEATH
	Carroll :	Eugene	Haines							HONTH	DAY	YEAR	I A .
	4. SOCIAL SECURITY NUMB	ER	5. SEX	8. AGE (In y	rs. last birthday	IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	7. DATE OF BIT	RTH	8. BIRTI	IPLACE (State or Foreign
	215-20-8538		©XM 2 ☐ F	73	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day,		Count	n) land
<u>ب</u>	90. FACILITY NAME (If not int 4623 Araby	stitution, give st Church	Road					or LOCATI			9c. CO	unty of D	EATH
៩	RESIDENCE OF DEC												
DIRECTOR	10a. STATE	10b. COUNTY			10c. C	TY, TOWN (10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBER	FT	ederick			FR		rick					1 TES 2 NO
BY FUNERAL	4623 Araby	Church	Road				10	217			-	S.A.	WHAT COUNTRY?
5	11. MARITAL STATUS	estitute en a	12. WAS DECEDEN FORCES? 1			13.	WAS DE	CENDENT C	OF HISPAI	NIC ORIGIN? (Spe	city Yes or No-	14. RACI	E — American Indian, k, White, etc.
	1 Never Married 2 🔀 3 Wildowed 4 Divo		1945-1	WAR OR DATE				2 D NO			arc.)	71023	lite
		EDENT'S EDUC highest grade		16.	a. DECEDENT'	S USUAL O	CCUPATI	ON net of working	00	16b, KIND	OF BUSINESS/IN	DUSTRY	
COMPLETED	7 Elementary/Secondary (0-		College (1-4 or 5		life. Do NOT	use retired.)	ouring in	out or works	·w				1
N N				26	ervice	Man					erick G	as Co	
BE CO	17. FATHER'S NAME (First, MI Ira Haines	(ddle, Last)								ME (First, Middle, Ssard	Maiden Surname)		
2	19a. INFORMANT'S NAME (7) Catherine		- Wife		196. MAILIN	G ADDRESS	S (Street Chi	and Number	r or Rural	Route Number, City	y or Town, State, 2	ip Code)	nd 21704
	20a. METHOD OF DISPOSITI			20b. PL	ACE AND DATE	OF DISPOS	ITION/N	ame of			20c. LOCATION -		
	1. Buriel 2 Crematio	n 3 🗆 Remo	oval from State	cemeter M L	olive	other place)	ete	rv		2-21-19			ck, Maryland
	21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENGEE			22.	NAME A	ND ADDRE	SS OF FA	CIUTYCE	ffer Fu	orol	Homos
	1 Henry	1/2	! No	week	2						e, Frede		
	23. PART I. Enter the dispose, or he iMMEDIATE CAUSE (Fin disease or condition resulting in death)	Part Isliure. L	List only one cau	ise oryeach	I line.		Tians.	1			r reapiratory s	rrest,	Approximata interval Between Onset and Death
RTIFICATION	Sequentially list condition if any, lasding to immediates. Enter UNDERLY CAUSE (Disease or Injurthat initieted events	diate NG			ONSEQUENCE (
CERI	reaulting in deeth) LAST	T C	l										
CAL	PART II. Other algnifices	nt conditions	contributing to	deeth but r	not reaulting	in the un	derlyin	g cause (given in		WAS AN AUTOPSY PERFORMED?	24b	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
ăII											YES 2 NO		COMPLETION OF CAUSE OF DEATH?
Ž.													1 YES 2 NO
ž	DID TOBACCO US		RIBUTE TO CA						ERTAII	V 🗆			
PHYSICIAN	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26.	PLACE OF DE	OTHER			-				
2	1 YES 2 NO		1 Inpatient 2			4 🗆 Nun	sing Hon		sidence	6 Other (Spec			
10	1 Natural 5 🗆 I	Pending nvestigation	28a. DATE OF (Month, D		28b. TII	ME OF IJURY M	WC	IURY AT ORK? YES 2	NO	26d. DEŞCRIBE	HOW INJURY O	CURED	
_	3 Suicide 6 0	Could not be	26a. PLACE O building,	F INJURY — / atc. (Specify)	At home, term,	street, fact	ory, offic			281, LOCATION City or Town	(Street and Number, State)	or or Rural F	Route Number,
4	29a. CERTIFIER												
COMPLEIED	(Check only		ZIAN: To the beat of a:) and manner as stated.
	296 SIGNATURE AND TITLE	OF CERTIFIER	# -					29c, LICE	NSE NU	4BER	29d. DA	TE SIGNED	(Month, Day, Year)
	Juda-	1	1/1		m			1	73	659	•	15	17198
	30. NAME AND ADDRESS OF	ASS.	TII W	SE OF DEATH	(ITEM 27) (Typ	a Print)	edi	-e: (C	ampie	Rd	14	a gers town
	FEB 1 9	too)	32. REGISTRA	R'S SIGNATUI	RE					. 10			md
	· LD I O	(2,221.)	your do	welson	we walk								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 8 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Feb. 17, 1998 Louise Mae Hagan 3:05 AM 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Vindabona Nursing Home Braddock Hgts. Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 1 M 20 F Yrs. 93 216-48-6815 MI. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick Jefferson 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2405A Capland Rd. 21755 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - American Indien, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Yas 2 No Specify: Specify. 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest Elementery/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mothar's Neme (First, Middla, Maidan Surname) 17. Fether's Name (First, Middle, Lest) Howard Huffer Firma Schildknecht 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lynne Minnick (Daughter) 32 D St., Brunswick, Md. 21716 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cametery, crematory or other placa) 20c. Location - City or Town, Stete Burlal 2 Cremation 3 Removal from State Lutheran Cemetery 2/19 Middletown, Mi. 5 Other (Specify) 21. Signature of Funeral Service Liberise 22 Name and Address of Fecility
Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. Per Filler the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feliure. List only one cause on each line. Approximete intervel Between Onset end Death Immediata Cause (Finel disease or condition resulting In death) arterial thrombosis 3 days Sequentielly list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Diseese or Injury that initiated evants resulting in deeth) Lest Due to (or es e consequenca of): Due to (or es e consequenca of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 | Yes 2 | No 3 | Probably 4 | Unknown Dementia 24b. Were eutopsy findings evelleble prior to completion of cause of daath? 24a. Was an autopsy performed? 2 PNO 1 ☐ Yes 2 ☐ No 25. Was casa raferred to medical 26. Place of Deeth (Check only one) Othar: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Manner of Deeth 28a. Deta of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

10e Stete

Director

þ

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic svent, the Medical Examiner must be nothled at

nit. Peges 1 end 2 should be filed within 72 hours after of artment of Heelth and Mental hygiena. ortant: If Itam 27 Is marked other than "natural", or iter Injury or other traumatic svent, the Medical Experiment

permit. Pege Department of Important: If any Injury or

Baltimore, Maryland 21215-0020

the Marylenc

deeth

physicien and the buriel-transit USB BS attending

Examiner

Physician/Medical

à

Completed

Certification:

1 Naturel

2 Accident

3 ☐ Sulcide

29a. Cartifier (Check only one)

4 Homicide

29b. Signetura and title of cartifier

31. Date filed (Month, Day, Year)

signed by the a d be datached f peed

funeral

 Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifica To the Hospital or within 24 hours eft To the Funeral Di completely filled in

Division of Vital Records, P.O. Box 68760.

Medical

State Registrar

5 Pending

6 Could not be determined

Investigation

12 Certifying Phyelclen: To tha best of my knowledga, deeth occurred et the time, dete end pleca, end due to tha ceusa(s) end mennar es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end pleca, end due to the ceusa(s) and menner stated.

29c. License number

29d. Date signed (Month, Dey, Yeer)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

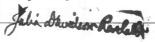
30. Name end eddress of person who complated cause of death (Item 23e) (Type, Print)

32. Registrar's Signatura

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

610 North Que, Brunswick, Md. 21716

1 ☐ Yes 2 ☐ No



A SAME OF SAME OF SAME OF SAME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Carland Oliver Huffer Feb. 15, 1998 12:10 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** College View Center Frederick If Under 24 Hrs. Frederick If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country)
 M1. 7. Age (In yrs. lest birthday) **Funeral** Deys 1X0 M 2□ F 219-20-2702 90 Yrs Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahom 7 is marked other than "natural", or items 23s or 28s-f shot traumstic event, the Medical Exercises must be notified at 1 ☐ Yes 2 ☐ No Director Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5840 Catholic Church Rd. 21755 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No tf Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or item any injury or other traument. 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 6 store owner merchandise 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Oliver Huffer Amanda Arnold 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ruth E. Huffer (Wife) 5840 Catholic Church Rd., Jefferson, Md. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State Lutheran Cemetery 2/18 Middletown, Mi. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility

Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 23a. Part.—Enter the disease, or compile tions that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Due to (or es a consequence of): disease or condition resulting in death) Examiner Curuay artic ettanding physician and for usa as the buriel-transit Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown signed b Records. þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed peen has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifical completally filled in by the funeral director, Be 25. Was cese referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpetlent 3 | DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1- Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide t Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a, Certifier Medical

29c. License number

towy are bedence und 217ch

29d. Date signed (Month, Dey, Year)

State Registrar

29b. Signature and title of certifier

31. Dete filed (Month, Day,

Julia Stevidson Randall

who completed cause of deeth (Item 23e) (Type, Print)

1475 32. Registrer's Signature

Mo v s ne

State of Maryland / Department of Health and Mental Hygiene

			Decedant's Nam	na /Firet Middle I a				tificate of	Death		Reg. No.	U	1209
	Physic		Decedant S Nam			ZABET	Н	Hi11		2. Data of D Month Februa	Day	Year 1998	3. Tima of Death 12:40 AM
	/Medi Examii		4e. Fecility Nama (a street and number))		117.7.1		r Location of Dee			12.40 AM
			FREDER	ICK MEM	ORIAL HO	SPITA	<u>. </u>		FREDER	ICK	FRED	ERIC	K
	Funeral Director		5. Social Security N 220-10	-5829	Sax 7. Ag 1□ M 2□XF 9	ge (In yrs. last 5	birthday) Yrs.	If Under 1 Year Months Days		n. 8. Data of B Month, D NOV •	irth ley, Year) 9.1902	9. Birthpl Count MD •	laca (Stata or Foraign try)
	pue M		Usual Rasidance of 10a. State	f Decedant 10b. County		10c. City, To	own or Loc	ation				10	Od. inside City Limits
	Manyl f she	jo	MD.	FREDER	ICK	FREDI							1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Nu	mber				10f. Zip Coda			10g. Citizan of	What Coun	try?
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Balt	Depertment Important any injur		21. Signature of Fu	unaral Service Licer	ISBB / . A			Nama and Addr	ass of Facility				
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O.	the ett hed fo	sici	Part II. Other signif	licant conditions c	ontributing to death b	ut not rasultin	g in the un-	derlying causa g	ivan in Part I.	23b. Dic	I tobacco uss co	entributs to	the causs of death?
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	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certifical completely filled in by the funeral director,	edical C	29a. Certifier (Check only one)	1⊠Certifying Ph 2□ Medical Exam	yalclan: To the bast niner: On the basis of and manner st	f axamination	lge, deeth and/or inva	occurrad at tha t astigation, in my	ima, data end pla oplnion, daath oc	ce, end dua to the curred at tha time	a causa(s) and m , data end plece,	annar as stand dua to	ated. the causa(s)
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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Death **Physician** Margarette Harding February 12, 1998 11:45 PM /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Yaar If Undar 24 Hrs. 8. Deta of Birth
Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthpiece (State or Foreign Country) **Funeral** Months Deys 1 M 2 F Yrs 219-14-9829 Director Aug. 11, 1919 Maryland Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner numbe notified at Maryland Frederick Frederick 1. Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 1421 Taney Ave. 21702 United States Funeral Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pagas 1 and 2 should be filed within 72 hours aftar. Department of Haalth and Mantal Hygiane. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event 1 ☐ Yas 2 ☒ No If Yes, Give Year or Datas: 1 Navar Married 2 Married 1 ☐ Yes 2 No Specify: à 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6 Electric Co. Inspector 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Car1 C. Cromwell Lena 0 Ulrich 19a. Informent's Neme/Reletionship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 712 N. Market St. / Frederick, Md. 21702
ace of Disposition (Name of Dete 20c. Location - City or Town, State James R. Harding, Jr./ son 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 1 Surial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Resthaven Memorial Garden2-16-98 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signetura of Funerel Sarvice Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. 1621 Opossumtown Pike / Frederick, Md. 21702 Approximate Intervel Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) PNeumener Examiner Due to (or es a consequence of): Examiner My Styne physician end the buriel-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? the 1 Yes 2 No 3 Probably 4 Whiknown arting distant þ 24b. Were eutopsy findings aveilable prior to completion of ceusa of deeth? 24a. Wes an autopsy performed? Completed peen has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours eftar deeth.

To the Funeral Director: After this cartific, completely filled in by the funeral director, 25. Was cese referred to medicel examiner? Be 26. Place of Deeth (Check only one) 2 Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1- Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not ba 3 Sulcide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piace of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide TCertifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to tha ceuse(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signatura and titla of certifian 29c. Licansa numbar 29d. Data signed (Month, Day, Yaer)

completed cause of deeth (Item 23e) (Type, Print)

Tawa

100 Sun 14 32. Registrar's Signature

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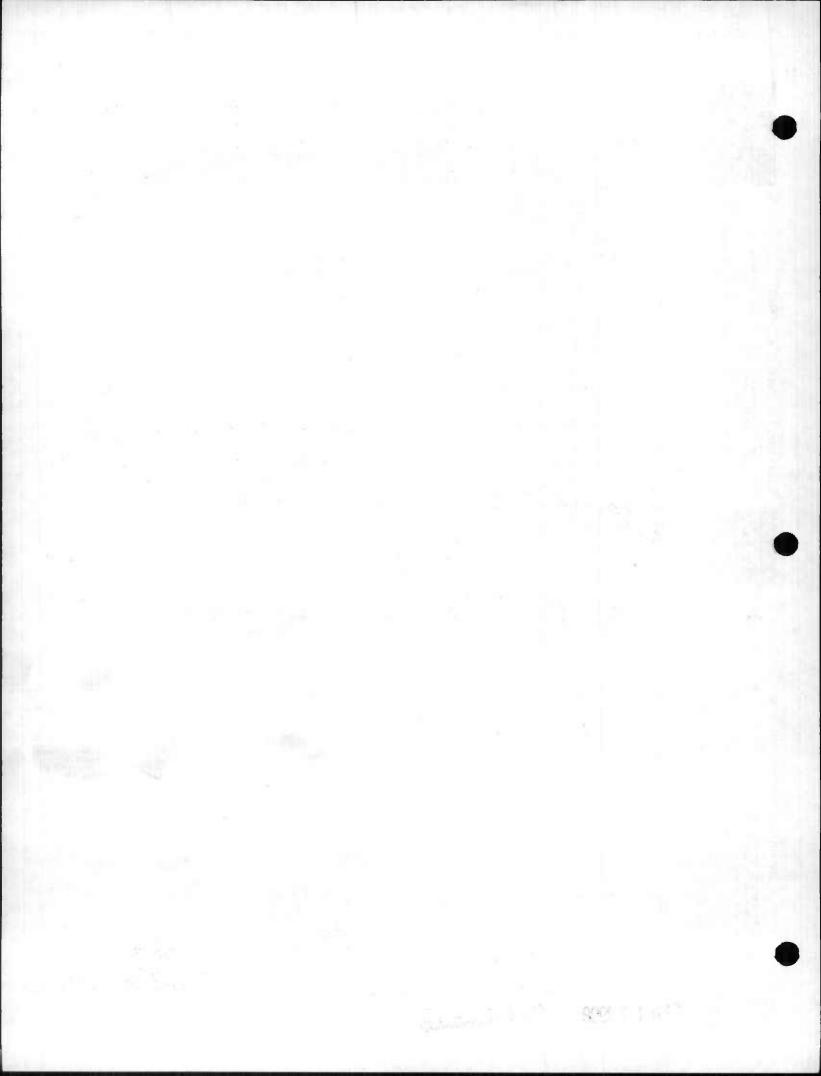
au, felench and 2/102

State Registrar

Saltimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month lones 4 mber 20 0108 4a. Facility Nama (If not Institution, giva streat and number) 4b. City, Town, or Location of Daath 4c. County of Daath of Muryland Shock / Transma Bultimore University If Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foraign Country) Months Days Hours 1 M 2 1 F 214-90-3444 Nov 8, 1977 MD Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 TYas 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3625 Valley Terrace Apt. B9 21244 U.S. 12. Was Dacedant Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 ☐ Yas 2X No If Yas, Give Yaar or Datas: 1X Navar Married 2 ☐ Married 1 Yas 2 No Specify: Black Specify: 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantery/Secondary (0-12) Collaga (1-4or 5+) 12 Shift Manager Fast Food 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama) Bruce Jones Jeanette Bivens 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Coda) 3625 Valley Terrace, Apt. B9, Baltimore, MD 21244 Bruce & Jeanette Jones/parents 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) John Wesley UMC Cemetery 2/28/98 Deal Island, MD 21. Signature of Fancial Sarvica Licensaa 22. Nama and Addrass of Facility Lewis N. Watson Funeral Home 1618 West Rd., SAlisbury, MD 21810 and. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximata Intarval Batween Onsat and Death Immediata Cause (Final disaesa or condition rasulting in daath) Thom bosis Sequantially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Causa (Disaasa or Injury that Initieted evants rasulting in deeth) Last Dua to (or as a consequance of): Extra coped Pulmunary assist Dua to (or as a consaquance of) Kespinatury Failure Part II. Other algnificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the causa of death? Multiorgan Enilare 1 ☐ Yas 2 ☐ No 3 Probably 4 Unknown Cerebral 24b. Wera autopsy findings available prior to 24a. Was an autopsy In fact

Physician /Medical Examiner

permit. Paga Department o important: if any injury or once.

Physician

/Medical

Examiner

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Pagas 1 and 2 should be filed within 72 hours aftar death with the Maryland nent of Haalth and Mantal Hygiene.
Int: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show Iry or other traumetic event, the Medical Examinating the notified at

Baltimore, Maryland 21215-0020

Examiner physician and the burial-transit Physician/Medical ō paga 2 should Be

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

signed by the a this cartificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifications of completely filled in by the funeral director, to 2

25. Was cesa rafarred to medicel

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27. Mannar of Death

1 Naturel 2 Accidant

3 Suicida

4 Homloida

28a. Data of Injury (Month, Day Year)

28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

complation of causa of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No

26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify)

1 Inpatiant 2 ER/Outpatiant 3 DOA 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as stated.

2 Medicat Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at tha time, dete and place, and dua to the cause(s) and manner stated. 29a. Certifiar (Check only one) 29b. Signatura and titla of certifiar 29d. Data signad (Month, Day, Year)

Fellow Critical Care

29c. Licansa number H0051578

30. Nama and address of person who complated ceusa of death (Itam 23a) (Type, Print)

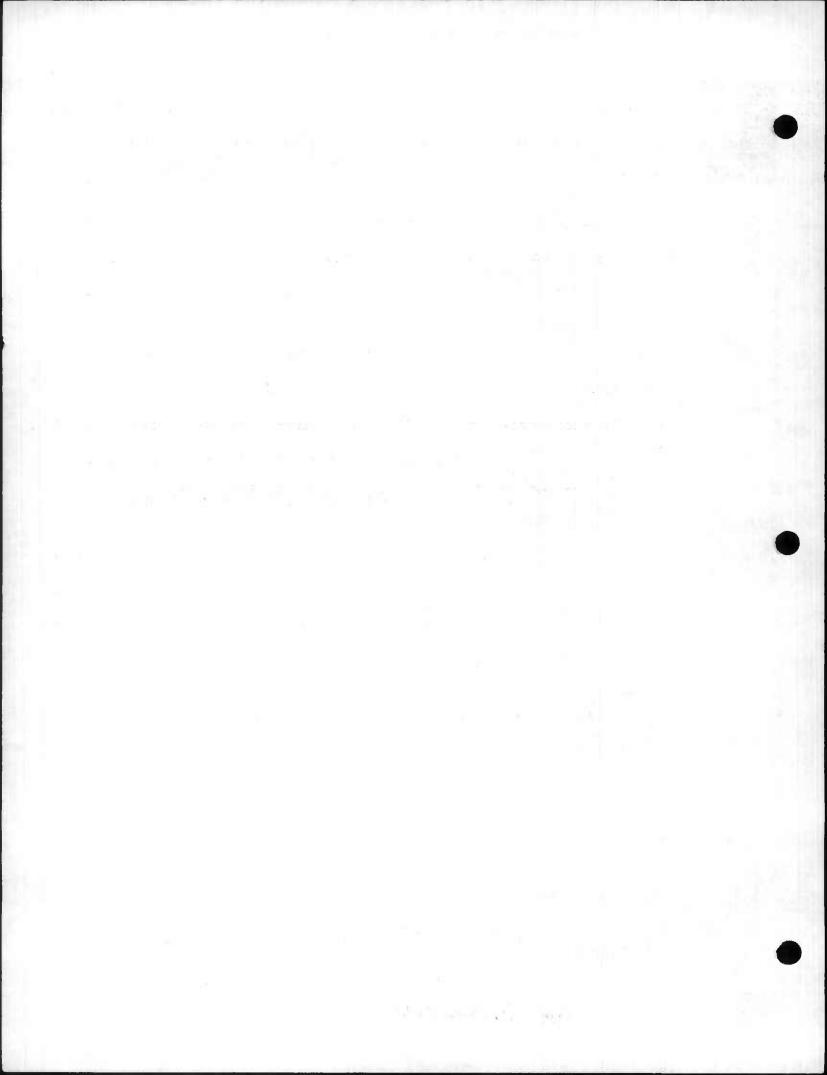
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State Registrar

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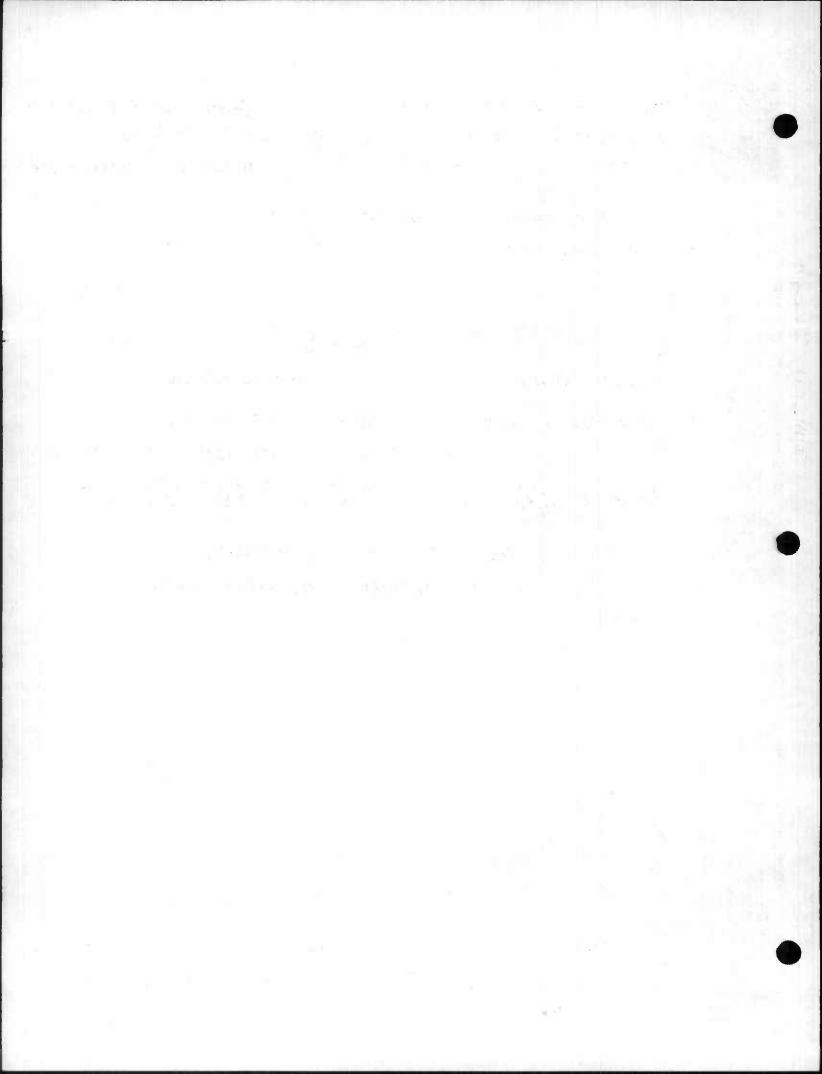
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State of Maryland / Department of Health and Mental Hygiene

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/Medi Exami		4a. Facility Name (If not institution,		nber)				4b. City, Town, or Glen Bu		eth 4c. Count		
Funeral Director		5. Social Security N		3. Sex 1 X M 2□ F	7. Age (In yrs. 92		thday) if Ur Yrs. Mont	nder 1 Year ths Days		8. Date of B	Jan.	9. Birthple	ce (State or Foreign News, VA
2		Usual Residence of	Decedent 10b. County		10c. Ci	ity Town	or Location						d. Inside City Limits
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em 27 i		Jeanette B. Jacks 20e. Mathod of Disposition	on (W	ite)	20h P		1.1 Westches Disposition (Name		Ct., Midd	Letown, M	20c. Location	City or To	Ctoto	
Important: If item 27 is any injury or other trau		1 ☑ Burial 2 ☐ Cramation 4 ☐ Donetion 5 ☐ Othar	(Specify)			em atar	y, cramatory or oth ille Cemete	ar pla	ice)	2/21	Browns			
any in		21. Signature of Funeral Service	LO	de_					Thompson F)		
siclan		23a. Part1. Entar tha disaasa, shock, or haart failura. Li	or complete st only	cations that ceus e causa on aach	sed tha daat n lina.	h. Don	ot antar tha moda	of dyi	ng, such as cardia	ac or raspiratory a	rrast,	1	Approxima Interval Ba Onsat and	tween
ledicai aminer		Immediata Causa (Final disaasa or condition	a	CART	DIAC	A	2PHYTH	u.	A				Mwst	43
<u> </u>		resulting In deeth)	- 6		Works	CF	4RDIOW						2 34	vea
physicien and the buriel-transit		Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury	5	COR			consequence of):	D	is ease				254	1ea
S		that initiated avents resulting in death) Last	ر		Dua to (o	rasac	onsaquance of):							
by the ettending petached for use as a stached for												1		
detached to Physic	F	Part II. Other significant condi				_	, ,	ısa gi	van in Part I.	23b. Dld	tobacco use co	ontributa t	the cause	of dea
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should be	-	ADULTONS						3			an autopsy ormad?	av	ara autopsy ailabla prior mplation of deeth?	to
age 2										10	Yas 200 No		∃Yas 2□	
is certificate he director, page		25. Was cesa raferrad to medic	cal			/			26. Placa of Da	ath (Chack only	ona)			
To F		axaminar? 1 ☐ Yes 2 ☑ No	Н	ospital: 1 🗆 Inpa	atiant 200	ER/Out	tpatient 3 DOA	Oth	har: 4 Nursing I	Homa 5□ Rasi	dance 6 □Oth	nar (Specif	(y)	
= 8		Z L Mooldani	stigation	28a. Data of fr (Month, L	njury Day Year)	28b. T	ima of 280 hjury M	c. Inju Wo 1 □	ryat rk?]Yas 2∐No	28d. Dascribe	how Injury occur	rred		
within 24 hours effer death. To the Funeral Director. After the completely filled in by the funeral Medical Certification:		3 Suicida 6 Cout 4 Homicide date	d not be mined	28a. Place of building,	Injury - At ho atc. (Specif	oma, far	m, straet, factory,	office		28f. Location (City or To	Street end Numi wn, Stete)	ber or Rure	al Route Nun	nber,
within 24 hours end To the Funeral Dir completely filled in Medical Cert		29a. Cartifier 1 Cartify (Check only one)	ing Phys al Examin	Iclan: To the basis ar: On the basis and mannar	of examinal	wledge, tion and	deeth occurred at for investigation, in	tha tin	ma, data and place opinion, daath occ	e, and dua to the urred at the tima,	ceusa(s) and m date and place,	ennar as s and due to	tated. tha ceuse(s	s)
Toth		29b. Signatura and titla of certif	de.	e Oe	· V	10	> 7	0	sa number 20488		29d. Data signa	1-98		
	3	30. Nema and addrass of person		poleted ceuse of			Type, Print)	Po	Box (7	MIDI	CHETOC	UN	am,	217

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Feb. 12, Ruth Amanda Jackson 1998 1:25 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Healthcare Center Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr. 17, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 25 F Yrs. 214-74-0728 Director 93 MI. Usual Residence of Decedent the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MI. Frederick Thurmont. Director 1 TYes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? death with 21 Howard St. Apt. 6 21788 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or item any injury or other traumatic event, tra Medical Exerction 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2K No Specify: ρ Specify White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) honemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be John Nicholas Adkins Mary Frances Ford 19a. Informant'e Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Helen I. Shank (Daughter) 21 Howard St., Thurmont, Md. 21788 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from State Harmony Cemetery 2/17 Myersville, Mi. 4 ☐ Donation 5 ☐ Other (Specify) of Funanti S 22. Name and Address of Facility
Donald B. Thompson Funeral Home 31. E. Main St., Middletown, M. 21.

That I enter the disease, or don plications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. erval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner ettending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? ate hes been signed by page 2 should be detect 1 Yes 20 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? After this certificate hes 1 Tes 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

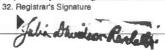
To the Funeral Director: After this certified 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 42 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and menner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 16, 1998 and eddress of person who completed cause of d eth (Ite 23a) (Type, Print) 1080 W. Patrick St Frederick, MD 21703 Andrew ZARICK, Jr

State Registrar

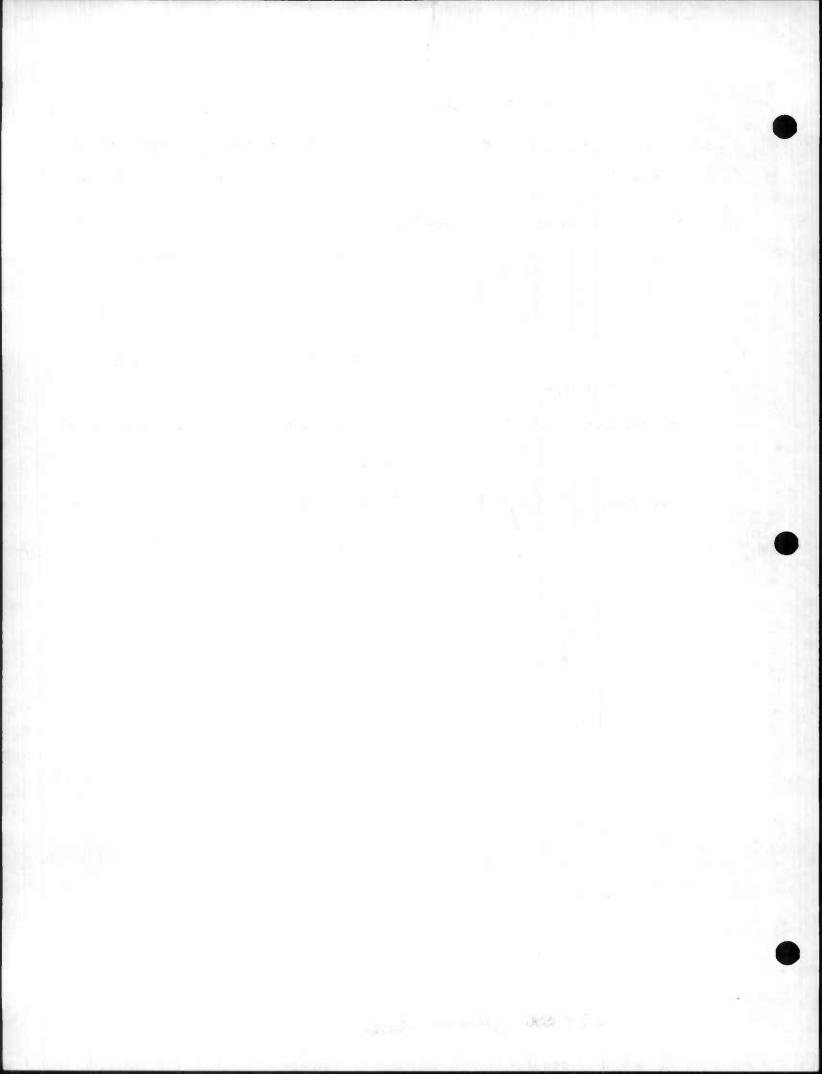
FEB & 0 1998

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

				Cer	tificate d	of Death		Reg. No.	07	215
Physici	an	1. Decedent's Name (First, Middle, Les					2. Date of De Month	eeth Dey	Year	3. Time of Deeth
/Medic		Dorot		ler		41 On T	Februa	ry 12, 1		9:15pm
Examir Funeral Director	ner	4a. Facility Name (If not institution, give SHADY GROVE AD 5. Social Security Number 203-30-0719 Usual Residence of Decedant	VENTIST HO	SPITAL vrs. lest birthday) 56 Yrs.	If Under 1 Your Months Da	4b. City, Town, or ROCKV ear If Under 24 Hr. ays Hours Min	IIIE s. 8. Data of Bi	MON	TGOME 9. Birthplace Country	CRY ce (Stete or Foreign sylvania
Mo to		10a. State 10b. County	10c.	City, Town or Lo	cation				10d	I. Inside City Limits
r 28a-f sh motified	Director	Maryland Montgome 10e. Street and Number	ry	amascus	10f. Zip Coo	de		10g. Citizen of \	What Country	1 ☐ Yas 2 ☒ No
23a o		10603 Sweepstakes	Road		208	72		United	State	es
the Medical Exerciant Living be notified at	by Funeral	11. Marital Status 1 □ Never Married 2☑ Married 3 □ Widowad 4 □ Divorcad	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If	Vas Decedent Yes, specify (☐ Yes 2√2	of Hispanlc Origin? (Cuban, Maxican, Pue No <i>Specify:</i>	Specify Yas or Norto Ricen, etc.)		e - Americen ck, White, ato	n Indian, c.
Medical	Completed	15. Decedent's Ed (Specify only highest green	ucetion de completed) College (1-4or 5+)	16e. Deced (Give life. L	ent's Usuel Ockind of work do NOT use re	ecupetion one during most of wo stired)	orking	16b. Kind of B		
		12		Lo	an Off			Bank		
	To Be	17. Father's Name (First, Middla, Last) Leonard Schaeffer				Dorothy	eme (First, Middle y Reinoe	h1		
		19a. Informant's Name/Relationship (7				reet end Number or F				40
ury or other traumatic		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐	Removal from State	 b. Place of Disposemetery, crem 	sition (Neme one tory or other	plece)	Date	20c. Location -	City or Town	n, State
eny injury or o		4 Donation 5 Other (Specify 21. Signature of Funeral Service License			. Name and A	tery 2, dress of Facility Molesworth	/17/98			aryland
= • a	. 1	23a. Part1. Enter the disease, or compshock, or heart feilure. List only of	lications that ceused the d	26	401 Ri	dge Road,	Damascu	s. Maryl	and 2	20872 pproximate nterval Between
siclan edical miner		Immediate Cause (Final disease or condition	. breast	ca	ncer				H	onset and Death
	Iner	resulting in death)	Due t	o (or as a conseq	uence of):					
pnysician end s the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	o (or as a conseq	uence of):					
0.0	n/Medical	that initiated events resulting in death) Last	Due to	o (or as a consequ	uence of):					
ached	Physician/	Part II. Other algnificant conditions co	ntributing to death but not	resulting In the un	nderlying cause	e given in Part I.				he cause of deeth?
should be del	eted by							en autopsy ormed?	comp	eutopsy findings eble prior to pletion of causa
36.2	Completed						1□	Yes 22(No	of de	V
s certificete director, pag	Be	25. Was cese referred to medical examiner?	Hospital: 🕰				eth (Check only	one)		
10 E	- T	1 ☐ Yes 2 No 27. Menner of Death	28a. Date of Injury	2 ER/Outpatien 28b. Time of			Home 5 ☐ Res	how injury occur		
Director: After d in by the funer	cation	1, Natural 5 Pending 2 Accident investigation 3 Sulcida 6 Could not be	(Month, Day Year) Injury		Injury at Work? 1 □ Yes 2 □ No				
led in by	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.		eet, factory, off	ice		(Street end Numb wn, Steta)	er or Hurel F	routa Number,
completely filled in by the funer	edical	29a. Cartiflar (Check only one) Certifying Phy 2 Medical Exam	raician: To the best of my iner: On the basis of exam and manner stated.	knowledge, death Ination and/or Inv	occurred at the estigation, in r	e time, date and plac ny opinion, death occ	e, and due to the curred at the time	cause(s) and ma date and piece,	anner as stat end due to th	ed. ne cause(s)
Eloo	2	29b. Signatura and title of certifiar	igul "	0	29c. Lic	cansa number		29d. Data signe	d (Month, De	y, Yaer) , 1998
		30. Name end eddress of person who on 18/11, PRINCE	ompleted cause of death (Item 23a) (Type, I	Print) DA	Y, NA	9 RATA	GOPAL,	M.D	
Sta Begistr	te	31. Determed (Month, Dey, Year)	32. Registrar's Si	gnature		(177)				
Registr 1 16 Rev 6/98		EB 1 8 19	98 Julia	welear Ran	65					



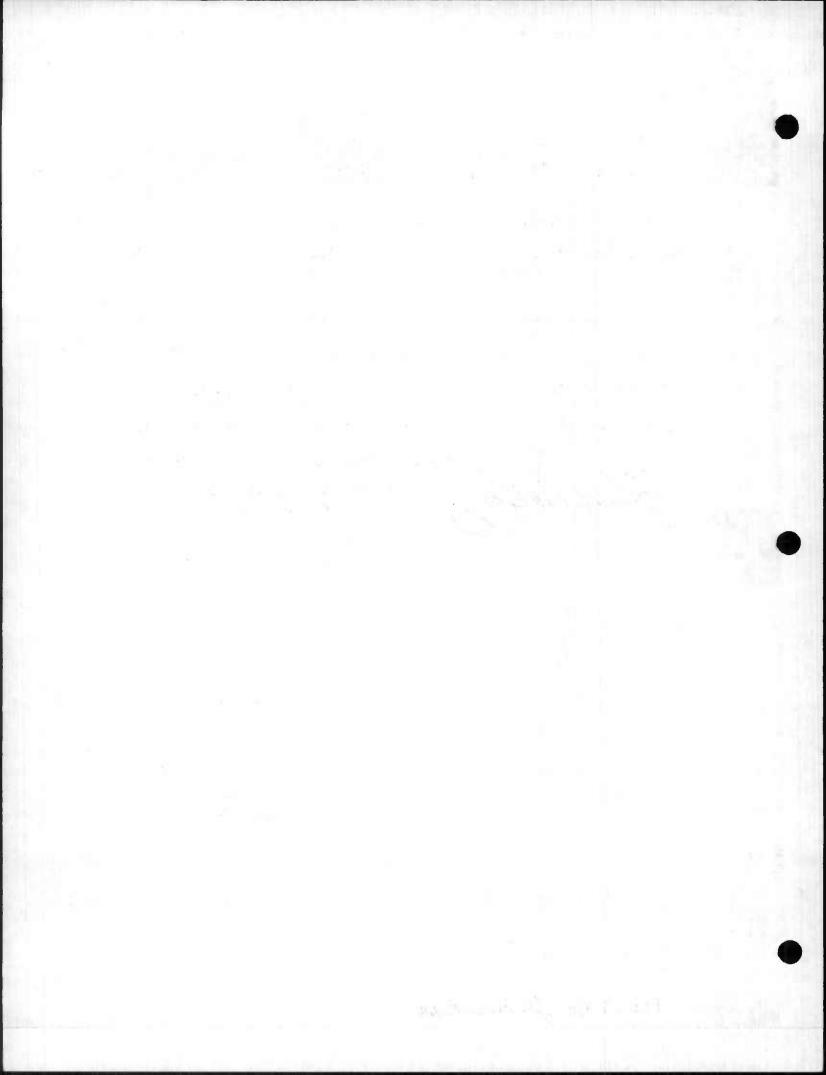
State of Maryland / Department of Health and Mental Hygiene O

						Certi	ificate of			Reg. No.	U	1216
	Dharata		1. Decedant's Nama (First, Middla, L.	ast)					2. Date of De Month	ath	Yeer	3. Tima of Death
	Physici /Medi Examir	cal	Henry Irving Layı	nan				4b. City, Town, or I	Februa		998	8:55 AM
и	Examir	ner	411 N. Bentz Stre					Frederick		Frede		
Н	Funeral		5. Social Security Number 6.	Sax 7. Age	(In yrs. last bi		If Under 1 Yea	If Under 24 Hrs.	8. Deta of Bir (Month, Da			laca (Stata or Foreign
	Director		214-10-2829	1⊠M 2□F	82	Yrs.	Months Days	Hours Min.		y, Year) 3, 1916		
	D.	1	Usual Rasidance of Decedant							, 1710	nary	Land
	show	h.	10a. Stata 10b. County		10c. City, Tow	n or Loca	tion				1	Od. Inside City Limits
	Ne M	Director	Maryland Frederic	k	Freder	ick						1 Vas 2 No
	Vith t		10e. Street end Number				10f. Zip Code			10g. Citizen of V	What Coun	itry?
	23	ral	411 N. Bentz Stre				21701			USA		
	J within 72 hours after death with the Manyland ilona. Than "natural", or Heme 23a or 28a-f show the Madical Examiner must be notified at	Funeral	11. Maritel Status	12. Was Decedant E Armed Forcas?		13. Wa	is Dacedent of as, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puart	pecify Yes or No o Rican, etc.)	- 14. Rac Bled	e - Amaric k, White,	
20	rs af	by F	1 ☐ Never Marriad 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yas 2 □ N If Yas, Giva Yaar or Dates:	10	10]Yas 2]∑No	Specify:		Specify		
21215-0020	tura tura	Pa	15. Decedant's E		169	Deceder	nt's Usual Occu	pation		16b. Kind of Bu	Whi	
15	n n	Completed	(Specify only highest gr	ada completed)		(Giva kir	nd of work done NOT use retin	during most of wor.	king	TOD. KING OF DE	1311162241116	Justry
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פ		BeC	17. Fathar's Nama (First, Middle, Las	")				18. Mothar's Nan	na (First, Middle,			
<u>a</u>	0 0 0	To B	William Henry La	vman				Rosia M	ae Heffr	ner		
Maryland	d 2 ahould be th and Mental 7 is marked o traumatic eve		19a. Informent's Neme/Ralationship		19b	. Mailing	Address (Stree	t end Number or Ru			Steta, Zip	Code)
	250		C. Lorraine Laym	an, wife	4	11 N	. Bentz	Street,	Frederi	ck, MD	2170	1
Baltimore,			20a. Mathod of Disposition	-	20b. Piece o	f Dispositi	ion (Nama of tory or other pla	ace)	Data	20c. Location -	City or To	wn, Stata
Ĕ	Pag nent int: I		1 ☑ Burial 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Othar (Speci					al Garden	2/19/98	Frederi	ck. N	Maryland
a	Departing Imports any injurante.		21. Signalum of Funaral Sarvice Lice	nsaa			lama and Addr			Funeral		
m	88 5 5 8		Nua Th	Raci		16	21 Opos	sumtown P				21702
			23a. Fart Enter the disease, or con shock, or heart tailura. List only	plications that causing	the death. Do	not entar	tha moda of dy	ing, such as cardiac	or respiratory e	rrest,		Approximeta
	Physician		Since of man tallula. List only	one ceusa dyeach in	4.		. 1		1		1	Intarval Between Onset end Daath
71	/Medical		Immediata Ceuse (Final disease or condition	(1)	noush		Hons	x Fai	luse		I	1111
	Examiner		resulting in death)	a	Due to (or es e			, , , , ,				190
-	D 45	je L			0							
	and trans	Examiner	Saquentially list conditions,	Ь.	Dua to (or as a	consequa	nce ot):					
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×	nding use as			d							į	
Вох	eath ce attandir for use	Physician/									1	
о. О.	that tha de led by the a datached	ıysi	Part II. Other significant conditions	contributing to death bu	t not rasulting l	n tha unda	ariying cause g	van in Part I.				the cause of death?
	as that igned b		asthma						10	Yes 2 No	3 Prot	bably 4 Unknown
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æ	The law ate has b page 2 s	Completed										death?
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Vita		o Be	axaminar?	Hospital:	• • □ EB/O	4414	- OI	26. Place of Dea				
ō	Physic this eraid	7: To	27. Mannar of Deeth	1 ☐ Inpatlar	y 28b.	Tima ot	28c. Inju	4 LI Nursing H		dance 6 Other		/)
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N N	Attar octor by th	Iffice	3 ☐ Sulcida 6 ☐ Could not be datermined	28a. Place of Inju	ry - At homa, fa	ırm, street	t, tactory, office		28t. Location (S	Street end Numb	er or Rura	I Routa Number,
בֿ	s afte	Certification:	- I Hornicide	building, etc.	. (Браспу)				City or Tov	vn, Steta)		
	To the Hospital or Attanding Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier Cartifying Pt	ysician: To the bast of	my knowledge	e, deeth oo	ccurred et the t	ma, date end piece,	end dua to the	ceuse(s) end me	nner es st	eted.
	the H in 24 the F	ledical	one)	ninar: On the basis of end mannar stat	led.	ovor inves	algetion, in my	opinion, death occur	790 at tha tima,	data end piece, a	and dua to	ina cause(s)
	Meith Tot	Σ	29b. Signatura and title of certifier				29c. Lican	sa number		29d. Data signed	d (Month, I	Day, Year)
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			39. Name and accress of person who	complated causa of da	-		nt)	Co.	10	0.0	۸ ۶	
				a 10 197	1 . 3	NE-	N-	HUER	/W)	217	0 -	
	Sta		31. Data tilad (Month, Day, Year)	32. Ragistra								
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State of Maryland / Department of Health and Mental Hygiene

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	/Medi		4e. Fecility Neme (If not institution, g	ive street and n					4b. City. Tow	vn. or Lo	cation of Deeth			0.	00 141
	Exami	ner													
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	Funeral		O.S. A.C. 77.62	Sex 1 M 2 ☐ F		rs. last birthday, Yrs.	Month			Min.	8. Date of Birth (Month, De) 9/25/2	Year)	9. Birthpi	ece (Stete	e or Foreign
	Director		023-10-1103		73	113.					9/25/2	4	Mass	achus	setts
	p .		Usuel Residenca of Decedent 10e. State 10b. County		100	City, Town or L	agation						T 40	and an elider	Ola di terito
	ahow	-			100.								10		City Limits
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	h wi	9 0	14532 Jackson Bl	vd.				218	822			US	A		
	filed within 72 hours after death with the Maryland Hygiena. "natural", or frems 23a or 28a-f ahow ent, the Mexical Examiner must be notified at	Funeral Director	11. Marital Stetus	12. Wes Dec	edent Ever in	U,S. 13.	Wes De	cedent of	Hispenic Orlg	in? (Spe	cify Yes or No- Rican, etc.)	14. Rec	e - America		
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K	should be filed within and Mental Hygiena. I marked other than umatic event, It a M	2	Joseph Mello Sr						Mar	ia	Carval.	lio			
Maryland	0 0 5		19a. Informant's Name/Reletionship	(Type, Print)		19b. Mail	ing Addra	iss (Stree	et and Number	r or Aura	I Route Numbe	r, City or Town,	Stete, Zip	Code)	
	Heelth Heelth em 27		Agnes Mello/Wife	е		145	532 J	Jacks	on Bly	d.	Eden. N	1D 21822 20c. Location -	2		
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п			23 Part. Enter the disease, or co	mplications that y one ceuse on	caused the g	eth. Do not en	ter the m	ode of dy	ring, such as c	cardiac c	r raspiratory er	rest,		intervel B	Setween
	Physician												į	Onset en	d Deeth
	/Medical		Immediate Cause (Final disease or condition	net	estatic	5-11	Ce	11	Carcin		-+	heat		2 ~	nons
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n		.uo	27. Menner of Deeth 1 Naturel 5 ☐ Pending	28e. Date (Mor	of Injury oth, Day Year)	28b. Time o	of	28c. Inje	ury et ork?	1	28d. Describe h	ow injury occur	red		
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ō	s after I Dirac	en	Tomode /	Dulio	ling, etc. (Spe	city)					Chy or You	11, 5(6(6)			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death FEBRUARY 20,1998 **Physician** SISTER ELEANOR MCNABB E:50 A.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner EMMITSBURG
If Under 24 Hrs.
Houra Min.
8 VILLA ST. MICHAEL FREDERICK If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys 1□M 201F Virs Director 92 058-03-2039 NOV. 18, 1905 MASSACHUSETTS Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rail, or itame 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director MARYLAND FREDERICK **EMMITSBURG** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 333 SOUTH SETON AVE. 21727 U. S. A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Haalth and Mentai Hygiene. Important: If Itam 27 is merked other than "natural", or its any injury or other traumatic avant, the Medical Exercises once. 1 ☐ Yes 2 🗓 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Aq Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'e Education (Specify only highest grade completed) 16b. Kind of Business/Industry RELIGIOUS COMMUNITY Elementery/Secondary (0-12) College (1-4or 5+) **ADMINISTRATION** DAUGHTER OF CHARITY 17. Father'a Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be PATRICK JOSEPH McNABB ELEANOR McCALL 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 333 S. SETON AVE., EMMITSBURG, MD. 21727 SISTER CAMILLA HARANT 20b. Pleca of Disposition (Neme of cametery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) JOSEPH'S 2/23/98 EMMITSBURG, MD. 21727 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner ence Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resuiting in death) Last dio mya Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an eutopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 D Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide

iaw requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attanding Physician: To the Hospital or Attar within 24 hours after dar To the Funeral Directo complataly filled in by th

with the Mandand

death ,

Baltimore, Maryland 21215-0020

physician and the burial-transit has cartificate director. after death. Diractor: After this funarai

Certification:

edical

State Registrar 29e. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certified

29c. License number

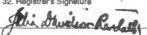
29d. Date signed (Month, Dev. Year)

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Rempel-GORTIER

FEBRUARY 20, 1998

32. Registrer's Signeture



DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Yaar ELSIE H. MCKINNEY 4:40 PM FEBRUARY 149 8 14 /Medical 4a. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deat 4c. County of Death Examiner BALTIMORE BALTIMORE SINAL HOSPITAL OF 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
JAN • 28 , 1924 MI • 9. Birthplace (State or Foraign Country)
MI • VERNON, MD 7. Aga (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 💢 F 219-14-3472 64 Yrs. Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location Thust be notified at 10d. Inside City Limits 1 Yes 2 No Director PRINCESS ANNE SOMERSET 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21853 13571 HANDY'S ROAD items 23a USA death 12. Was Decedent Ever In U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after Hygiena. Ither than "netural", or ite 1 Navar Married 2 Married SpecifyAFRO-AMERICAN Baltimore, Maryland 21215-0020 1□ Yes 2□ No Specify: by 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work dona during most of working ifle. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2yrs College (1-4or 5+) Elementary/Secondary (0-12) BEAUTICIAN COSTOMOTOLY ages 1 and 2 should be filed int of Health and Mental Hygie if item 27 is marked other t 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JESSE HOLBROOK MAGGIE KING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code, 1317 T. STREET, S.E., WASHINGTON, D.C. 20020 LEONARD T. BURKE 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stata permit. Pages 1 Department of H Important: If its any Injury or ot PAUL UM CHURCH CEM. 1 X Burial 2 ☐ Cramation 3 ☐ Removal from State 2-21 MT. VERNON, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Service Licensee JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD; SALISBURY, MD. 21801 23a. Part. Firtar the disease, or complications that osused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Death Physiclan /Medical Immediate Cause (Final WITH NEUTROPENIA SEPSIS diseasa or condition resulting in death) Examiner Due to (or es e consequence of): Physician/Medical Examiner CHEMOTHERAPI The law requires that the daath certificate be axecuted Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury attanding physician and for use as the bunal-trar OVARIAN Box 68760. CANCER that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Moknown SYNDROME SHORT GUT MALKBSORPTION Records, þ 24b. Were autopsy findings available prior to completion of causa Completed 24e. Wes an autopsy ABDOMINAL ABSCESSES has pege 2 HISTORY OF LOWER GASTROINTESTINAL BLEEDING 1 Yas 2 No 1 ☐ Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

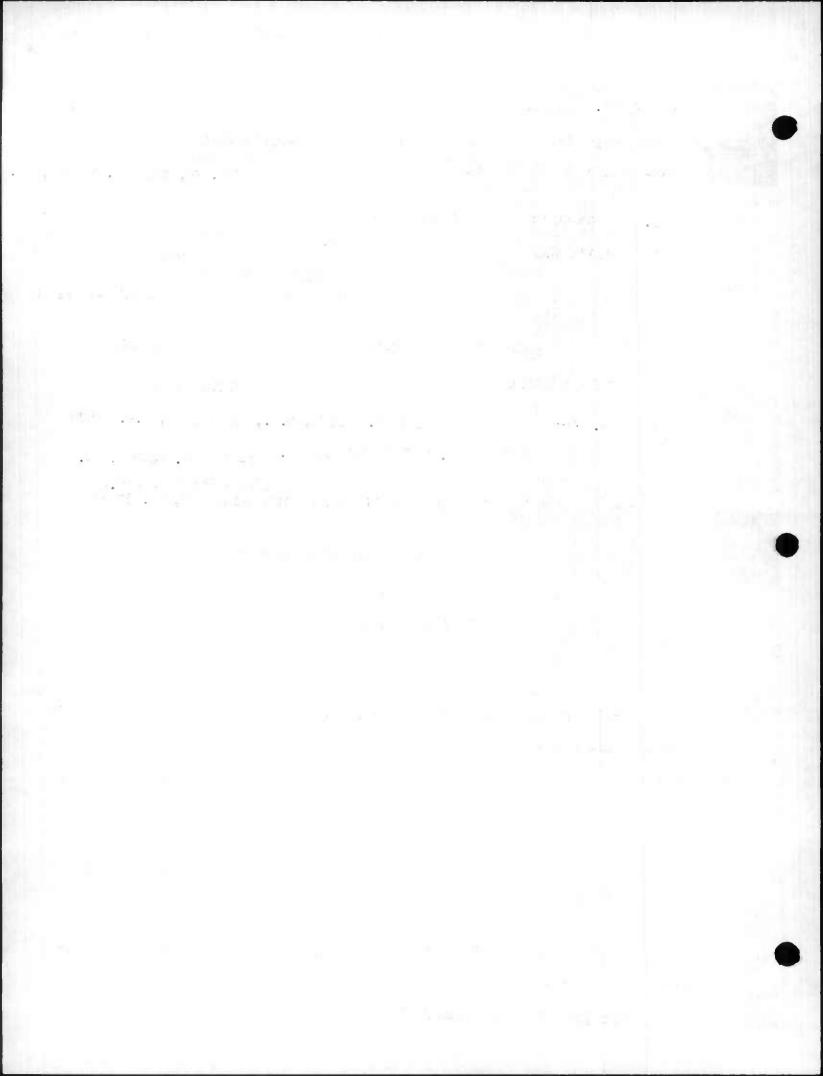
To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 Suppatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 27. Menner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide CertifyIng Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. 29e. Certifie edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Dev. Year) 10dos MD AS 2402321 - HT 9004 FEBRUARY 1998 ncea 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TODOR AVENUE SINAI HOSPITAL OF BALTIMORE, BALTIMORE, MD 21215
32. Registrar's Signature
July Standard 2401 WEST RELVEDERE AVENUE 31. Data filed (Month, Dey, Yeer)

DHMH 16 Ray 6/95

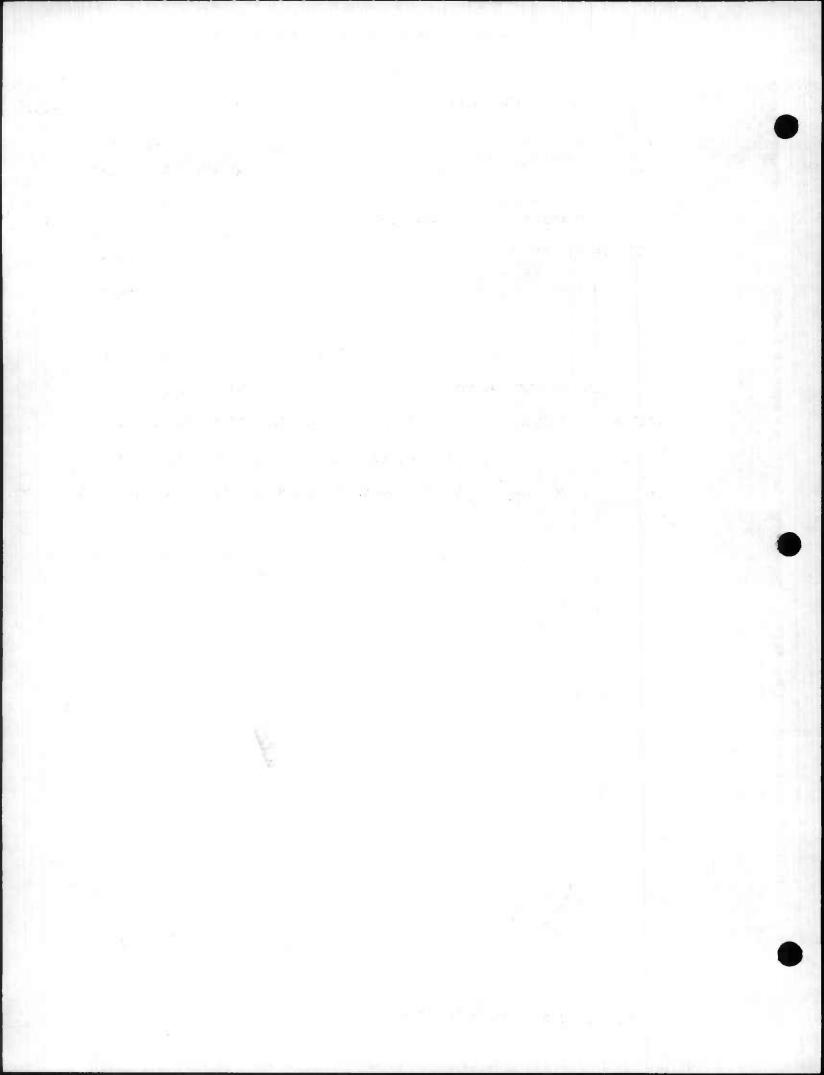
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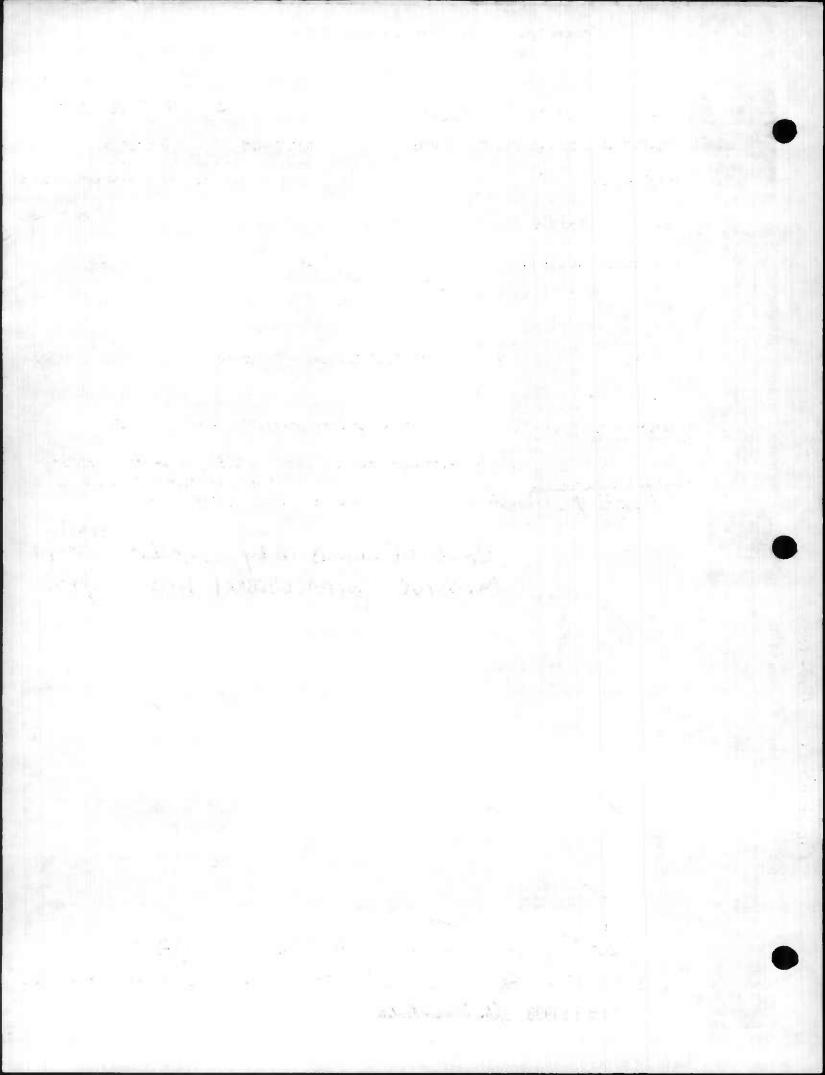
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Robert Nagel 101-14-8223

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	Funeral		PENINSULA 5. Social Security Nun		6. Sex	7	CAL CEN Age (In yrs. le	ast birthdey)	if Under 1 Year Months Days		BURY Hrs. 8. Date Min. (Mor	of Birth oth, Day, Year)	VICOM	ICO 9. Birthpl Count	lace (Stete or Foreign
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n of	ding Ph. Aftar thi funeral		27. Manne of Deeth	5 🔲 Pendi	ng 21	Be. Date of (Month)	Injury Dey Year)	28b. Time of Injury	Wo			scribe how Injui	ry occurre	d	
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Div	oftar Olred d in b	E L	4 Homicide	detern	nined -	building	g, etc. (Specify)	oot, ractory, office		City	or Town, State)		,
	To the Hospital or Attent within 24 hours efter deat To the Funeral Director: completing filled in by the	<u>a</u>							occurred at the t						
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(7.	sperde		30. Name and address	of person	who comple	eted cause	of death (Item	23a) (Type,	rice I	h A	201	Sou	BRU	4	NO 21801
	State	e	31. Dete filed (Month,	Dey, Year,	1000	32. Se	gistrar's Signet	ure o	44					1	
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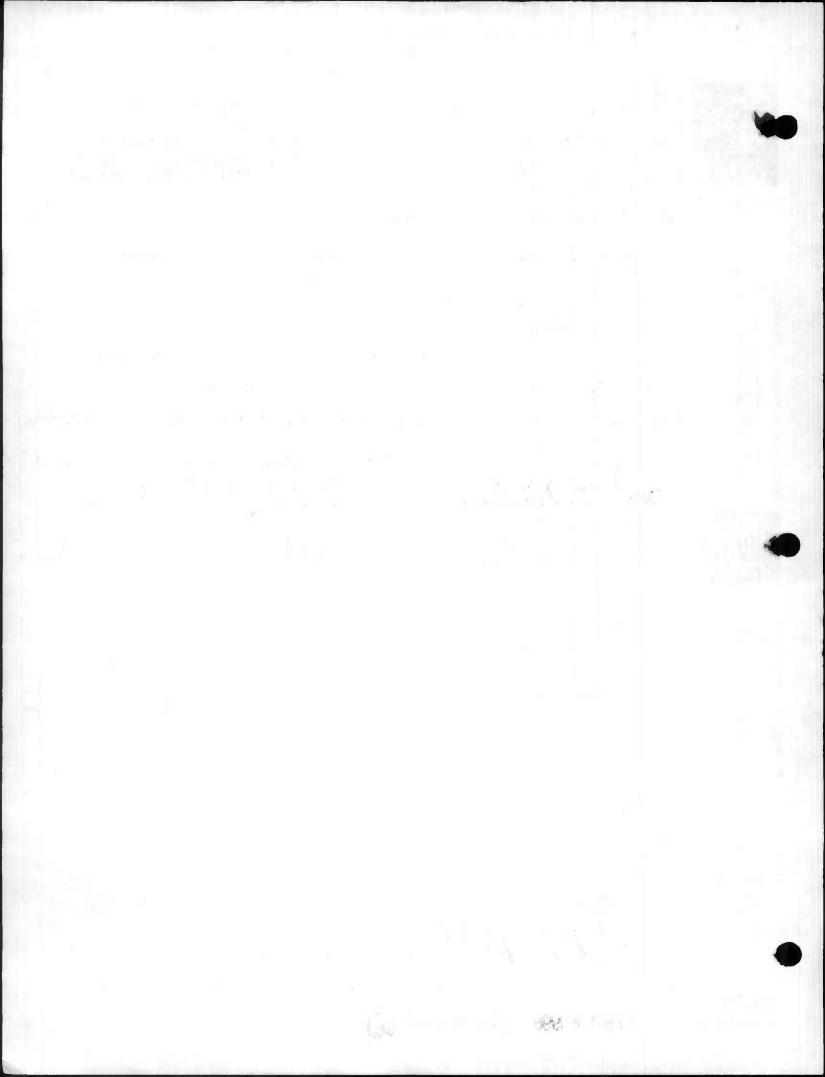
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** February 11, 1998 12:30PM Offutt /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 23339 Davis Mill Road Montgomery Germantown 8. Date of Birth (Month, Dey, Year) Jan. 17, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Yrs 80 1918 Director 578-12-5712 Maryland Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or Items 23a or 28a-f ehow the Mexical Examiner must be notified at Maryland Montgomery Germantown 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 23339 Davis Mill Road 20876 American 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 25No If Yes, Give Year or Dates: WWII Raca - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 end 2 should be filed within 72 hours effer to Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or harny injury or other traument. 1 Never Married 210 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorcad Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Musician Entertainment 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Malden Sumame) Be Walter C. Offutt Snyder Esther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor W. Offutt - Wife 23339 Davis Mill Road, Germantown, Maryland 20876 20b. Placa of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, cremetory or other pleca) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Doration 5 ☐ Other (Specify) Metropolitan Crematorium 2/13/98 Alexandria, Virginia ne of Fu eral Servica Licenses Olin L. Molesworth, P.A., Funeral Home overs 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, and failure. List only one cause on each line. Approximete Intervai Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 0 **Examiner** Due to (or as a consequence of) Examiner ettending physician and for use es the buriai-transit The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown þ 8 24b. Were autopsy findings available prior to completion of cause Be Completed 24a. Was an autopsy performed? peed of death? certificate hes page 2 1 🗌 Yes 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Was case referred to medical 26. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 2 🗌 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and plece, end due to the cause(s) and menner stated. Medical (Check only one) 29b. Signature and title of se 29c. License number 29d. Date signed (Month, Dev. Year) February 12, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth D. Miller, M.D. 18111 Prince Philip Drive, Olney, Maryland 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Jali Davidson Rankel Registrar

DHMH 16 Rev 6/95



ELIZABETH A. PHILLIPS Baltimore. Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 11:20 PM FEBRUARY SARAH ELIZABETH **PHILLIPS** /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HAURE DE NURSINGHOME GRACE HARFORD CITIZENS If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) **Funeral** 1□ M 2🛛 F Months Deys Yrs Director 216-38-9997 98 July 12,1899 Maryland Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Llmits item 27 is marked other than "natural", or items 28s or 28s-f show other traumstic event, the Madical Examiner must be notified at Director Harford 1 ☐ Yes 2√ No Maryland Havre De Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 100 REvolution Street 21078 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 No White Specify: P 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within: Department of Health and Mental hygiene. Important: If item 27 is marked other than "re any injury or other traumatic event, the Health any injury or other traumatic event, the Health Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be George Francis Adams Sarah Elizabeth Daniels 2 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Isabelle Stearn/Niece 3615 Level Village Rd., Havre DeGrace, MD 21078 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) St. Phillips Cemetery 2/21/98 Quantico, MD 22. Name end Address of Fecility Holloway Funeral Home SP 501 Snow Hill Rd., Salisbury, MD 21804 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one dause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting In death) Examiner Cen years Examiner the burial-transit Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest and Cerebrovascular Box 68760. ettending physiclan certificete be Physician/Medical Due to (or es e consequenca of) Brain as Syndrome use Pert tt. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. Records, P.O. the 23b. Did tobacco uee contribute to the cause of death? signed by t 1 Yes 2 No 3 □ Probably 4 □ Unknown þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peen page 2 has 1 ☐ Yes 2 B No 1 ☐ Yes 2 PNo certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifici Be 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: Other: 41 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth Certification: 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 I Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medicai completely (Check only one) 29b. Signature end title of certifier/ 29c. License number 29d. Date signed (Month, Dey, Year) 98 M-D

319 S. Union Ave., Havre De Grace, MD 21078

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

32. Registrer's Signature

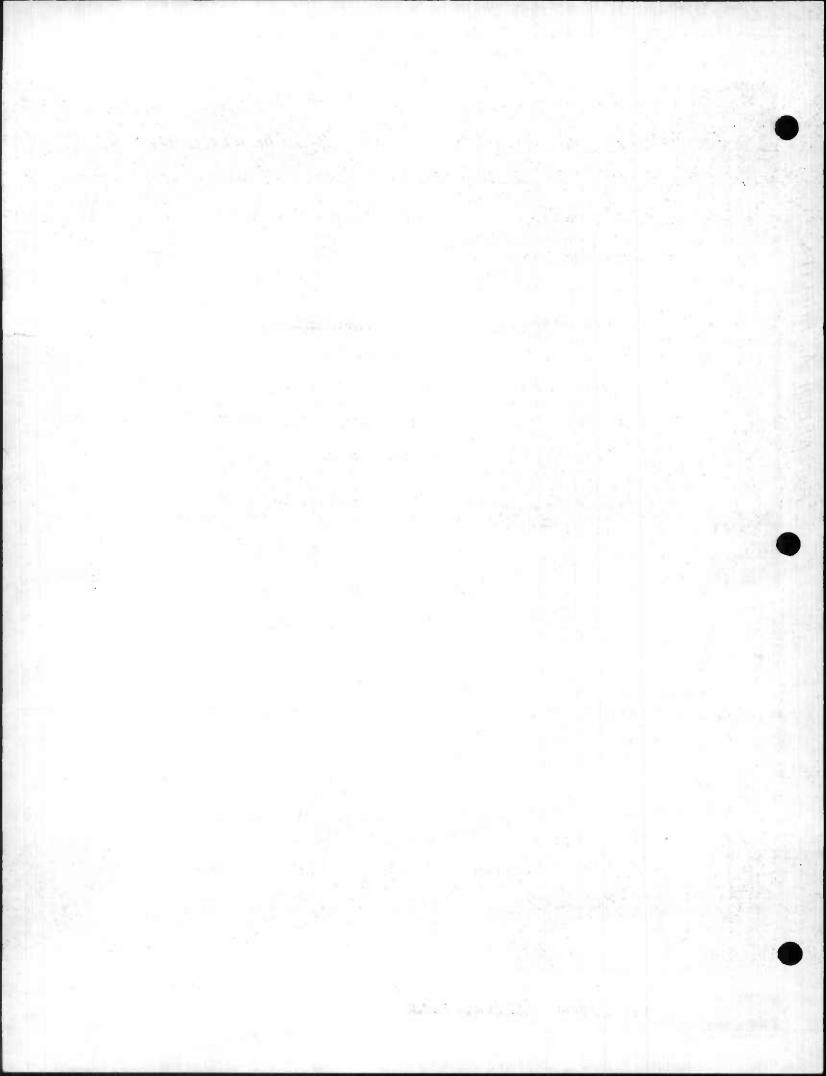
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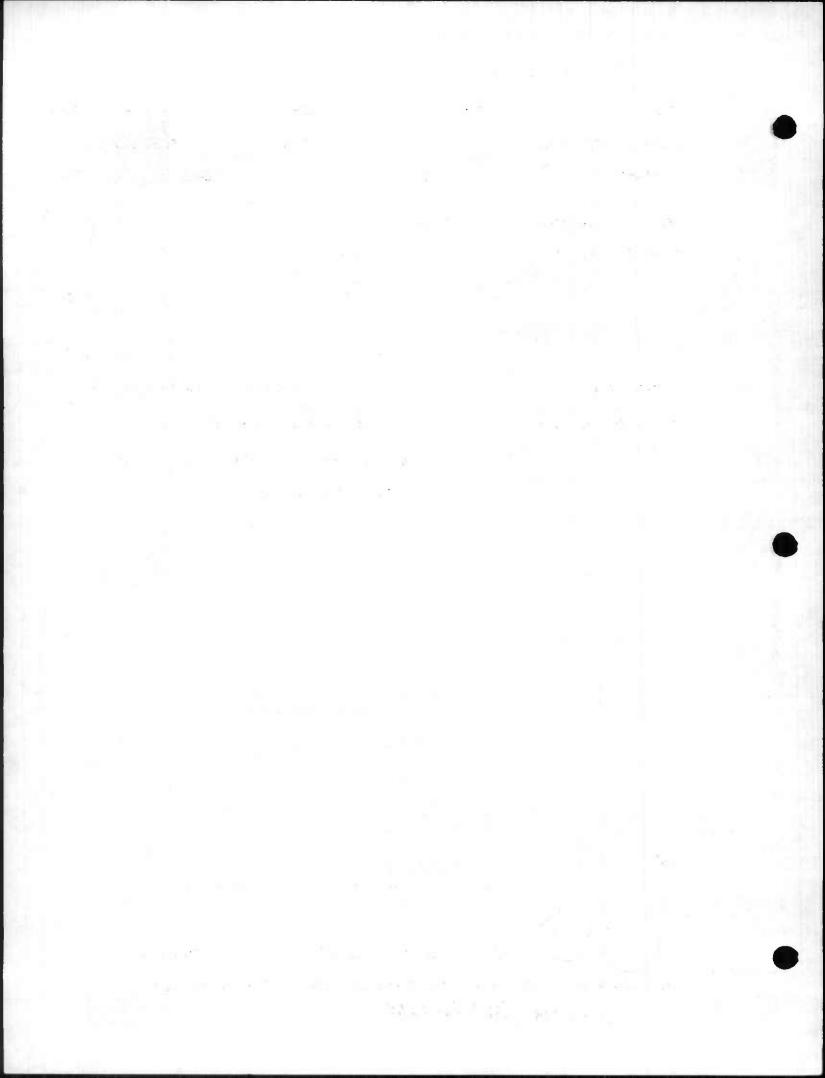
State Registrar



State of Maryland / Department of Health and Mental Hygiene

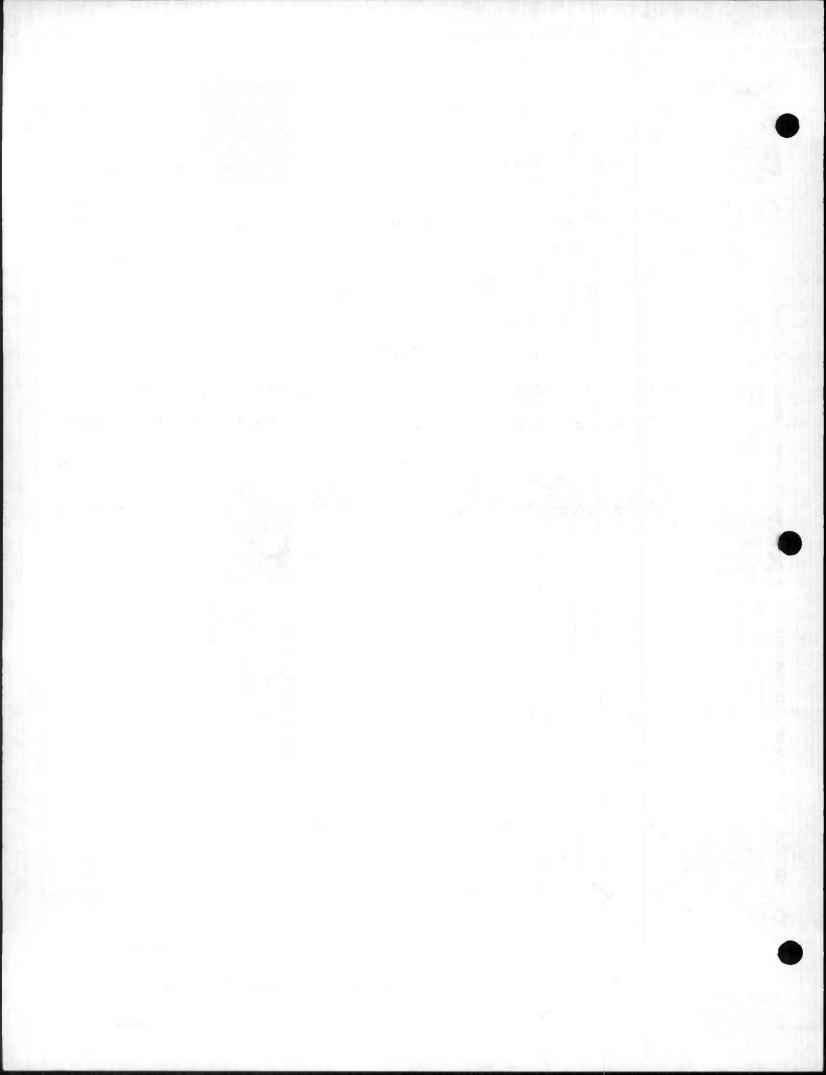
Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month Yaar JOHN ROBERT 02 98 2115 /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 31309 CARIOCA ROAD DELMAR WICOMICO 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. Birthplace (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1⊠ M 2□ F Director 217-42-5988 Yrs 52 07-18-45 Md. Usuai Rasidanca of Decedent the Meryland 10a Stata 10b County 10c. City, Town or Location 10d. insida City Limits r 28a-f show show 1 TYas 2 No Director Wicomico Delmar 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò other treumatic event, the Medical Examiner must be 31309 Carioca Rd. 21875 or items 23a USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐No If Yas, Giva Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican indian, Biack, Whita, atc. 72 hours efter 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 🏖 No Specify: White by Specify. 3 Widowed 4 Divorced "naturel", WHITE Completed Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within:
Department of Health and Mental Hygiene important: if hem 27 Is marked other than 'n eny Injury or other treuments. Elamantary/Secondary (0-12) Collaga (1-4or 5+) Owner, Logging Co. Logger 17. Father's Nama (First, Middla, Last) 18. Mothar'a Nama (First, Middia, Maidan Sumama) Be Milmon Payne Dorothy Lankford Payne 2 19a. informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Nancy Payne, Wife 31309 Carioca Rd. Delmar, Md. 21875 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Daurial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Brookview Cemetery 2-18-98 Brookview, Md. 21. Signatura of Funaral Service Licensea 22. Nama and Addrass of Facility Short Funeral Home - Hannigar Short 13 E. Grove St. Delmar, De. 23a. Parl 1. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or hearl failure. List only one cause on each line. Approximata intarval Betw Onsat and Death **Physician** /Medical immediata Causa (Final disaasa or condition rasulting in daath) GUNSHOT WOUND TO NECK Examiner Dua to (or as a consequance of): SELF-INFLICTED The law requires that the death certificete be executed buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated evants rasulting In daath) Last and Dua to (or as a consequence of): Box 68760. Physiclan/Medical the Dua to (or as a consequence of): ettending for use es Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Records, P.O. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deed hes page 2 certificate 1 Yas 20XNo 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician: director, 25. Was casa refarred to medical Be 26. Placa of Death (Chack only one) Hospitai: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 🖫 Rasidanca 6 Othar (Specify) 1 Yas 2 No 2 this 27. Manner of Death 28a. Data of injury (Month, Day Year) 28c. injury at Work? 28d. Dascribe how injury occurred Certification: 28b. Tima of Affer 1 Natural 5 Panding invastigation death. 1 ☐ Yas 2 No 1955 ^M 2 Accidant 02-15-98 efter death Director: SELF-INFLICTED GUNSHOT WOUND 3 Suicida 4 ☐ Homicida 6 Could not be Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of injury - At homa, farm, streat, factory, office building, atc. (Specify) 2 To the hosp... within 24 hours effer To the Funeral Dire HOME-31309 CARIOCA ROAD DELMAR MD 1 Certifying Physician: To tha best of my knowledge, death occurred at tha time, date and piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) 29a. Certifier Medical (Check only one) and mannar stated. 29b. Signature an 29c. Licansa number 29d. Data signed (Month, Day, Year) 120 D.M.E. H50497 02-16-98 ss of person who complated causa of death (Item 23a) (Type, Print) CHRISTOPHER S. SNYDER, D.O., 108 PINE BLUFF ROAD, SALISBURY MD 21801 31. Data filed (Month, Day, Year) Registrar's Signatura State FEB 191998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Marylar		ificate of			eg. No.	8 0	7225
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	Funeral Director	13		7. Age (In yrs.		If Under 1 Year Months Deys		8. Date of Birth (Month, Day NOV . 16	,1932	9. Birthple Count WASH	ace (State or Foreign in) INGTON, DC
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Loca	ation				10	Od. Inside City Limits
	Many Many	tor	MARYLAND CALVERT	CHE	SAPEAKE	BEACH					1□Yes 2□No
	or 28	Direc	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Count	ry?
	s 23a	eral	3340 TISWOOD COURT	10 West December 5 and 1	10 40 11	2073			U.S.		
21215-0020	filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or ferms 23a or 28a-f show ont, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2000 If Yes, Give Year or Dates:	II.	as Decedent of I Yes, specify Cub	Hispanic Origin? (S en, Mexican, Puert Specify:	pecity Yes of No- o Ricen, etc.)		e - America ck, White, e	etc.
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Maryland		ToE		AIGHT			DOROTH	Y FRAN	CES M	AGUIF	₹E
Mar	0 0 0		19e. Informant's Neme/Relationship (Ty) ROBERT WAYNE PLOT				t end Number or Ru				Code)
re,	es 1 end 2 of Health item 27 l		20a. Method of Disposition	20b. F	Place of Disposit	TISWOOD tion (Name of story or other ple	COURT CH	Date	BEACH, 20c. Location -		20732 vn, State
<u>m</u>	Pages nent of I ant: If ite ury or o		1 ☑ Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		EAVEN C		FEB. 20,1998	CIT TIED	CIDDIA	TC VD
Baltimore,	permit. Pages Depertment of Important: If it any injury or one		21. Signature of Funeral Service License	of at	22.1	Name end Addre	ess of Facility			SPRIN	IG, MD
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	Physician		shock, or heart tailure. List only or	cations thet used the leat le ceuse on each line.	th. Do not enter	the mode of dyi	ng, such as cardíac	or respiratory err	est,		Approximate Intervel Between Onset end Death
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	Hospital 24 hours Funeral letely filled	edical	29a. Certifier 1 Certifying Phye (Check only one) 1 Certifying Phye	elclan: To the best of my kno her: On the basis of examina	wiedge, death o tion and/or inve	occurred at the ti stigation, in my o	me, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and ma ate and place, a	nner as sta and due to	ited. the ceuse(s)
	To the within 2 To the comple	Mec	and manner steted. 29b. Signature end title of certifier 29d. Date sl							(Month, D	ley, Year)
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			30. Name and address of person who col			Int)			- III	10	
			Dr. Paul V. 31. Date filed (Month, Day, Year)	Pomilla.M.D		ce Frede	erick, Ma	ryland	20678		
	Sta Registr		FEB 2. 5. 199	32. Registrar's Signa	den P	44					

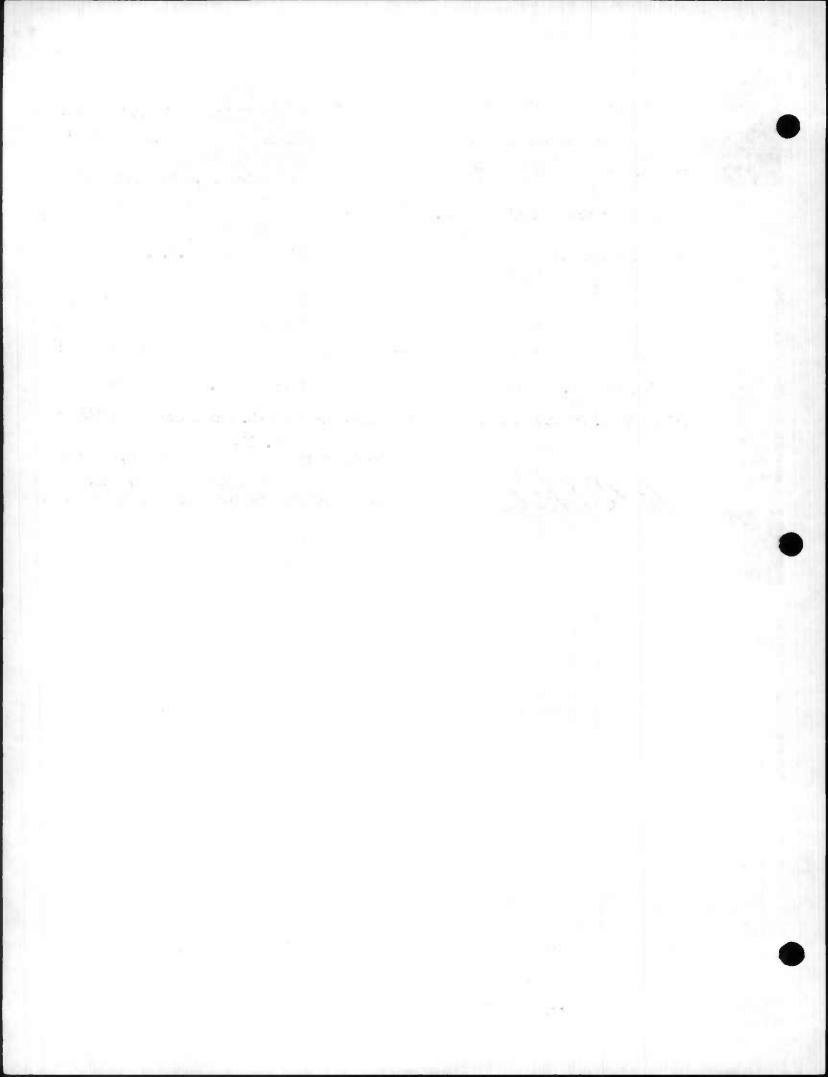


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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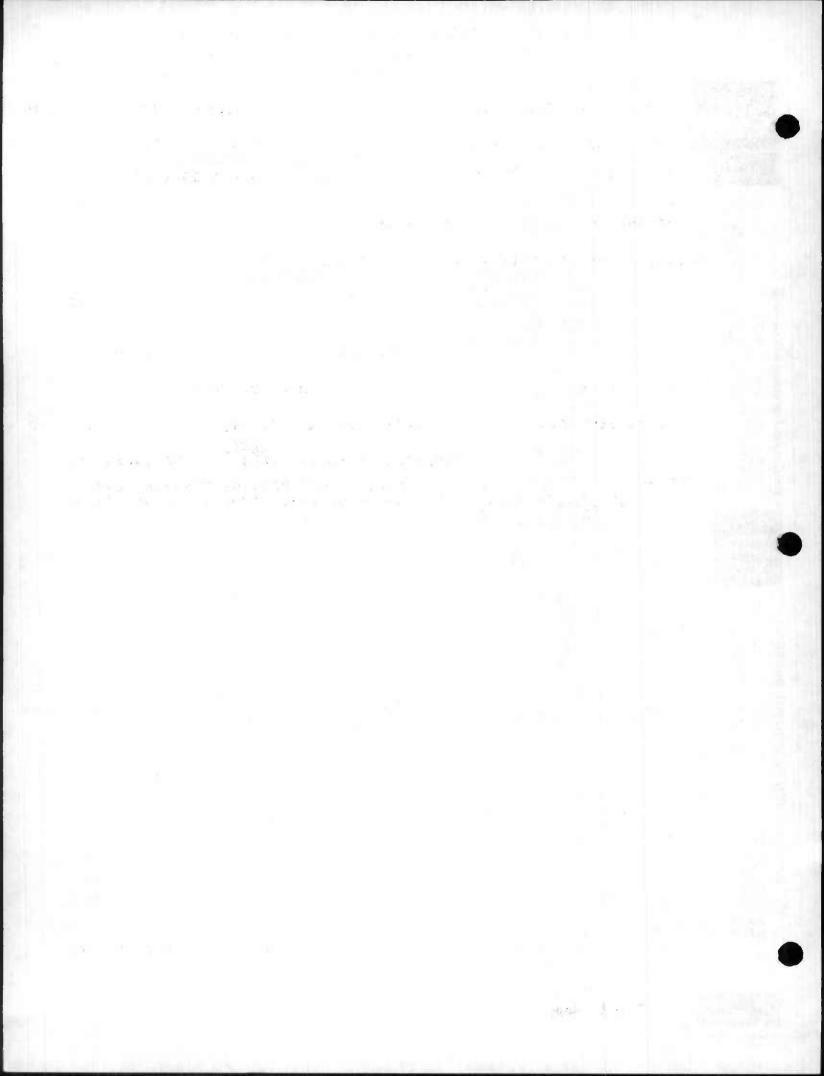
						Cer	tificate o	f Death	•	F	Reg. No.		1161	20
	Dhoole		1. Decedent's Name (First, Middle, Les	()						2. Dete of Dee	eth	V	3. Time	of Death
	Physic /Medi		Joseph	Sherman			Procto	2		Month Februai	Dey 7 17,1	Yeer 998	2.0	00 PM
	Exami		4e. Fecility Name (If not institution, give	street and number)				4b. City, To		cation of Deeth	4c. Count	y of Death		
1			Southern Maryl	and Hospital				Cli	nton		Prin	ce Ge	eorge'	S
	Funeral Director		5. Social Security Number 6. Se 577–20–7823 Usuel Residence of Decedent	7. Age (In yrs 78		thday) Yrs.	If Under 1 Yes Months Day		Min.	8. Date of Birth (Month, De) May 29			plece (Stete ntry) rland	e or Foreign
	pue Ma		10e. State 10b. County	10c. C	ity, Town	n or Loc	ation						10d. Inside	City Limits
	the Mary 28a-f sh	Director	Maryland Prince Ge	eorge's F	t. W	ash:	ington						1 □ Ye	es 2 No
	ath with 23e or		7904 Allentown Roa				10f. Zip Code	2074	4		U.S.A.			
0200-61212	72 hours efter death with the Maryland "natural", or Items 23s or 28s4 show added Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married → Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in \ Armed Forces? 1 □XYes 2 □ No If Yes, Give Yeer or Dates:	U,S.	It	Vas Decedent of Yes, specify Cu	iben, Mexica	n, Puerto I	cify Yes or No- Rican, etc.)		ick, White,	can Indian, etc. Black	
ה	72 h	eted	15. Decedent's Ed (Specify only highest gred	ucation de completed)	16a.	Deced	ent's Usual Occ	upation	at of working	na	16b. Kind of B	usiness/in	dustry	
7	filed within 72 ho Hygiene. ther than "natur int, the Wed col	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1 .	life. D	O NOT use reti	red)		.9	Automo	hilo	Potai	; 1
7			11th 17. Fether's Neme (First, Middle, Last)	N/A		Par	ts Mana		- d- Al	(First, Middle,			Recal	L.J.
ō.	a d fa	Be	Sydney F.	Proctor					rrie	F.		octor		
Maryland	d 2 should be th end Mental 7 is marked of traumatic sve	To	19e. Informant's Name/Reletionship (T	ype, Print)	196.	. Mailing	g Address (Stre	et and Numb	er or Rure	l Route Numbe	r, City or Town	, State, Zip	Code)	
	deal TH 2		Elizabeth E. Proct				atterio							
paillinore,	permit. Pages. Department of H Important: if ite any injury or ot once.		20a. Method of Disposition 1 Burial 2 Cremation 3 I 4 Donation 5 Other (Specify,	Removel from State	cemeter	y, crem	atory or other p	,	eb. 2	998	Clint			and
Dali	Departi Departi Importi any inj		21. Signature of Funeral Service Ligent				Neme and Add			e Fune a Ferry		•		20735
	Physician		23a. ⁵ art1. Enter II e diseese, or comp shock, or heert tailure. List only o	lications that caused the dea ne cause on each line.	ith. Do n							I	Approxime Interval Be Onset end	iete atween
	/Medical Examiner		Immediate Ceuse (Final disease or condition	MRSA	-	SE	PSIC						2we	ece
	- Xuiiiiiiiiii	1	resulting in death)	Due to (or as e c	consequ	uence of):						2 We	2 01 1
Т	pet lisit	F		b. Em	246	N	A						2000	reus
2	amecu and el-tre	xar	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	Due to (or es e c	onsequ	ience ot):							
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	has has	dm	As	ema								ot	death?	
	iclan: The certificate h rector, page									1□ Y	es 2 No	1[☐ Yes 2	□ No
-	ysician: is certific director,	Be	25. Was case reterred to medical examiner?	Hospital:				ther		(Check only or				
OI VIII		5 To	1 Yes 2 (No	1 Department 2	28b. T		3LI DOA	4 LI NI		ne 5 Resid			y)	
=	a fee	cation	1 □Natural 5 □ Pending 2 □ Accident Investigation	(Month, Dey Yeer)		njury	28c. Inj W M 1[ork? □Yes 2□		ou. Describe n	ow injury occur	160		
2	tal or Att rs efter d al Direct ed in by	Certification:	3 Suicide 6 Could not be 4 Homlcide determined	28e. Place of Injury - At h building, etc. (Speci		rm, stre	et, tectory, office	Ð	2	8f. Location (S City or Tow		er or Rura	il Route Nu	mber,
	To the Hospital or Attending Ph within 2 Hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29e. Certifier (Check only one) 1 Certifying Phy 2 Medicat Exami	elclan: To the best of my knowner: On the basis of examination and manner stated.	owledge, ation end	death Vor Inve	occurred et the estigetion, in my	time, dete en opinion, dee	d place, e th occurre	nd due to the c	euse(s) end <i>m</i> e late end plece,	enner es s end due to	tated.	(s)
	Within To th	Me	29b. Signeture end title of certifier	2 ,			29c. Licer	nse number		2	9d. Date signe	d (Month,	Dey, Year)	
			4	308			DI	1647	8		2-17	-98		
			30. Name end eddress of person who be	ompleted cause of death (ite	m 23a) (Type, P	rint)							
			Suresh A. Part	elmo 700	150	188	2its R	d #	307	Chi	nton.	mD	200	735
Γ	Sta	ate	31. Dete tiled (Month, Day, Year)	32. Registrer's Sign		P,								



State of Maryland / Department of Health and Mental Hygiene 8 Certificate of Death

		/Med Exam	ical iner
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5-0020	72 hours efter death with the Marylend	'netural', or items 23a or 28a-f show dical Examiner must be notified at	eted by Funeral Director

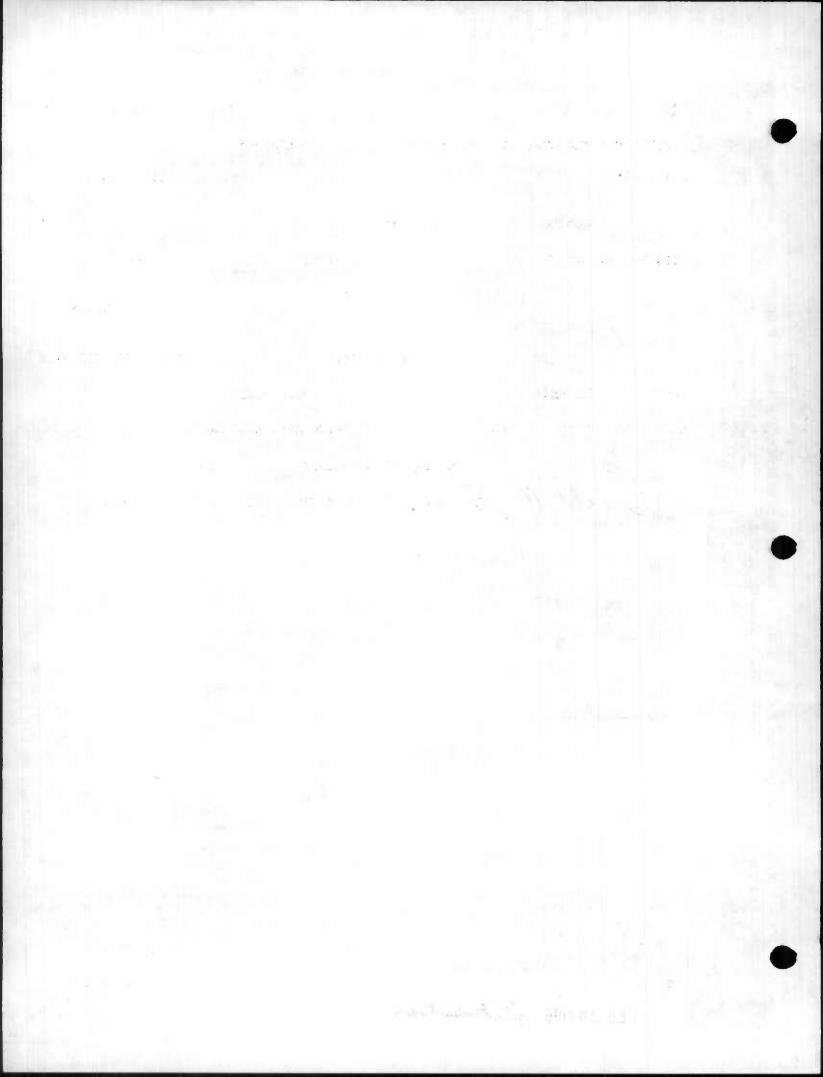
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Mend Mend		10e. Stete 10b. County	1	IOc. City, To	wn or Lo	cation				10d. Ir	nside City Limits
r 28a-f show	ţ	MARYLAND ALLEG	ANY	FRO	STB	URG				1	☐ Yes ※ No
or 284	Director	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Country?	
23a (20417 RUBY'S IN	DUSTRIAL.	ROAD		2153	2		USA		
ter death with Items 23a or Inst. mast be	Funeral	11. Marital Status	12. Wes Decedent Even Armed Forces?		13. V	Ves Decedent of I	lispenic Ori	gin? (Specify Yes or N., Puerto Ricen, etc.)	io- 14. Rad	ce - American In	dien,
s office	by F	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No if Yes, Give		1	Yes 20 No	Specify:		Specif		T. P.
72 hours effer death with the Maryland 'natural', or items 23s or 28s-f show dical Examiner must be notified at		15. Decedent's Ed	Yeer or Dates:	16	a Deced	lent's Usuel Occur	nation		16h Kind of R	usiness/industry	
s within 72 haliene. r than "natur	Completed	(Specify only highest gree	de completed)		(Give)	kind of work done OO NOT use retire	during mos	t of working	100. Killd 01 b	usinessindustr	,
	EO	Elementary/Secondary (0-12)	College (1-4or 5+)		HOU:	SEWIFE			OWN	HOME	
d 2 should be filed the and Mental Hyg 7 is marked other traumatic event,	Bec	17. Father's Name (First, Middle, Last)					18. Mothe	er's Neme (First, Middl	e, Maiden Sumer	ne)	
should bed and Menta	To	JAMES DE VAULT					RE	BECCA MET	rz		
and la me		19e. Informent's Neme/Relationship (7	ype, Print)	15	b. Meilin	g Address (Street	end Numbe	er or Rural Route Num	ber, City or Town,	Stete, Zip Code	e)
C = 01 F		ROY DE VAULT/S					MAN :	ST. SW, I	FROSTBU	RG, MD	21532
t of Hear If Hern or othe		20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐		20b. Plece cemes	of Dispos tery, crem	sition (Neme of netory or other ple	ce)	FEB		- City or Town, S	State
anti. Pa antimen ortant: injury	. 9	4 ☐ Donetion 5 ☐ Other (Specify		FROS		RG MEMO		PARK 1998	FRUST	BURG,	MD
permit. Pages 1 el Department of Hea reportant: If Nam any Injury or othe ance.		#1 Signature of Funerel Service Licens	500		H /	Name and Addre	OST I	MANSION I	FUNERAL	HOME	
00240		Juglas	1. tage		58	B FROST	AVE	., FROSTI	BURG, M		32
		23a Part1. Enter the disease or comp shock, or heert failure. List only of	ilicetions that ceused the	e deeth. Do	not ente	er the mode of dylr	ng, such es	cardiac or respiretory	errest,	Inter	roximate rval Between
Physician		Contract and Contract of				0.					et end Deeth
/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in death)	. AC47	E G	(PP)	SR AA	STROI	NIESTINA	16 Bleed	ling ?	39 Hou
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ted nsit	Ë						UL	CGRS.			
and and el-tra	Examiner	Sequentially list conditions, if any, leading to immediate	Du	e to (or es	e consequ	uence of):					
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ficete phy s the	edicai	resulting in deeth) Lest	Du	e to (or as a	consequ	uence ot):					
death certificate be executed e ettending physician and of for use es the buriel-transit	lcian/Me		d					-			
death e ette d for	cia	Pert II. Other significant conditione co	ontributing to death but u	not resulting	in the un	idertying ceuse giv	en In Pert I	23h Die	i tobacco usa co	intribute to the	cause of death'
	Phys	0 0 1						,	Yee 2010	3 Probably	
s the	by F	Uld. LBC	UNAR I	NAA	RE 1	heft.	Kenn	Pregio			
The law requires thet the de ate has been signed by the e pege 2 should be deteched							٠	24e. We	s en eutopsy formed?	24b. Were et	utopsy findings e prior to
> 00 CV	plet								ionneo:	complet of deeth	tion of cause
The lav	Completed							1	Yes 200	1 ☐ Yes	2 □ No
	Bec	25. Was cese referred to medical					26. Place	of Deeth (Check only	one)	1	
0 0	To	examiner?	Hospitei: 1 ☑ Inpatient	2 ER/0	Outpetient	t 3□ DOA Oth	ner: 4 🗆 Nu	rsing Home 5 Res	sidence 6 Oth	ner (Specify)	
ng Ph ter th nerai		27. Manner of Deeth 1 ☑ Neturel 5 ☐ Pending	28e. Dete of Injury (Month, Dey Y		Time of Injury	28c. Injui Woi	ry et rk?	28d. Describe	how injury occur	red	
Attending or deeth.	atic	2 ☐ Accident Investigation				M 1	Yes 2	No			
or Attending effer deeth. Director: Affer in by the lune	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc. (- At home, Specify)	ferm, stre	et, factory, office			(Street and Numb own, Stete)	ber or Rural Rou	ite Number,
tal of lar											
To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director: After th completely filled in by the luneral	edical	29e. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medicat Exam	rsfcien: To the best of n Iner: On the basis of ex	caminetion a	ge, deeth ind/or inv	occurred et the tir estigation, in my o	me, date an pinion, dee	d piece, and due to the th occurred at the time	e cause(s) and ma e, date end place,	anner as stated. and due to the	ceuse(s)
the thin the mple	Mec	29b. Signature end title of cartifier	end menner stated	d.		29c. Licens	se number	T	29d. Date signe	d (Month Dev	Vesr)
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6		On Name and old over 1	7	1 da	. /=	y 2	-70	38	FEBRU	ARY 261	אעע
TUS		30. Name and address of person who c	ompleted cause of deet	in (Item 23e	(Type, F	MAN.	10	1215	32		
		31. Date filed (Month, Day, Year)	32 Registrers	Signeture	IKG	Mary	and	0/0	20		
Sta Registi	_	FEB % 7 1998	San Charles	المثالة النب	14	*					



State of Maryland / Department of Health and Mental Hygiene

Physi	cian	Decedent's Name (First, Middle, Last) Betty Elizabeth Rankin					2. Date of Dea	Reg. No. ath Day	Year	3. Time of Death
/Med							FEBRU	ARY 25 1		13:16
Exam	lner	4a. Facility Name (If not institution, give street and no Sacred Heart Hospital	amber)			4b. City, Town, or L Cumberlan			of Death egany	
Funera Directo	_	5. Social Security Number 218-24-8692 6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. la 68		If Under 1 Year Months Days		8. Date of Birth Month, Dey 4-AUG	Year)	9. Birthpled Country Mary C	e (State or Foreign
and w		Usual Residence of Decedenf 10a. State 10b. County	10c. City,	Town or Local	tion				10d	. Inside City Limits
Many	ţo	Maryland Allegany	Eckh	nart						1 ☐Xes 2 ☐ No
th with the 23a or 28	Funeral Director	10e. Street and Number 1603 Laurel Hill,	s.w.		10f. Zip Code 215	28-		10g. Citizen of W		n
15-0020 72 hours effer death with the Maryland *neturel', or flems 23s or 28s-f ehow flest Examinel must be notified at	by	Armed F	2 ⊒ K No ive		s Decedent of les, specify Cub	Hispanic Origin? (Sp san, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American k, White, etc : White	
and Z1Z15-UUZU be filed within 72 hours ef tall Hygiene. d other than "netural", or event, the Medical Exert	Completed	15. Decedent's Education (Specify only highest grade completed Elementery/Secondery (0-12) College) (1-4or 5+)	16e. Deceden (Give kin life. DO Houseke	nt's Usual Occu nd of work done NOT use retire	pation during most of work ed)	ring	16b. Kind of Bu		stry
and be file d othe	To Be Co	17. Father's Name (First, Middle, Last) Bert A. Rîzer		11 20 21 21 21		18. Mother's Nam		Melden Sumem	e)	
Ma nd 2 ilth ar lith ar 127 is		19a. Informant's Name/Relationship (Type, Print) Karen Green Daugh	nter			t and Number or Rui Pike, S.W. Fro			State, Zip Co	
Baltimore, Nominal Peges 1 and 3 Department of Health mportant: if Item 27 and in July or other in the state of the state		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	State Cer	ace of Dispositi metery, creme berland C	tory or other ple		Date 6-Feb-98	20c. Location - Cumberle		
Baltimo permit. Pege. Department of Important: If it is any injury or or or or or or or or or or or or or	N N N N N N N N N N N N N N N N N N N	21. Signature of Funeral Service Lightsee	4		iame and Address rst Funero	ess of Facility Il Home, 57 f	rost Ave.,	Frostburg,	MD 21	532
√ Physiclar		23 Pert1. Enfer the disease, or complications that shock, or heart feilure. List only one ceuse on	caused the death. each line.	Do not enter	the mode of dyl	ing, such as cardiac	or respiratory ar	rest,	Africo	pproximete itervel Between inset end Deeth
/Medica Examine		Immediate Cause (Final disease or condition resulting in death)	CUIE (Pul n	was	y Fail	ure		1	up hus,
od dansit	Examiner			P Leu as a conseque	1	ffring	* ARC	NES	10	o lags
D&/DU, ifficate be executed g physician and as the bunel-transit		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	aucil	alite	1				6	useles
E 0 4	v/Medical	that Initiated events resulting in death) Last	0 5	as a conseque		och			3	weeks
death cert death cert a attendin	Physician/N	Part II. Other significant conditions contributing to c	leath but not result	ting in the unde	erlying cause gi	iven in Pert I.	23b. Dfd t	obecco use con	tribute to th	ne cause of deeth?
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aw requir	Completed b				_	·	24a. Was a perfor	an autopsy med?	evaile	aufopsy findings able prior to eletion of cause ath?
The The cate he	Con						1 🗆 Y	es 2 No	1 🗆 Y	res 2□ No
Of VItal I Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical exeminer?	/ -		_ Ot	26. Place of Deel				
Phys ral di	5	1 ☐ Yes 2 ☐ No ☐ 105 pitel. 1 ☐ 27. Menner of Death 28a, Dete		R/Outpatienf 28b. Time of	3□ DOA 28c. Inju	4 □ Nursing Ho	ome 5 Resid	ence 6 Other		
DIVISION O for Attending Ph after death. Director: After th d in by the luneral	Certification:	2 Accident investigation 3 Suicide 6 Could not be	e of Injury - At hom ling, etc. (Specify)		M 1	ork?]Yes 2□No		Street and Number		loute Number,
To the Hospital or A within 24 hours after . To the Funerel Dire completely filled in b	edical Ce	29a. Certifier Certifying Phyaician: To the (Check only one) Medicaf Examiner: On the band man	e best of my knowl basis of examination	ledge, death or on and/or inves	ccurred af the fi	ime, date and place, opinion, death occur	and due to the cred at the time, c	cause(s) and ma date and place, a	nner es state and due to th	ed. ne cause(s)
o the	Me	29b. Signature and fittle of certifier)		29c. Licen	se number		29d. Date signed	i (Month, Da	y, Year)
3		· augueral	Dogue		D	13168		FEBRU	ARY)	6,1998
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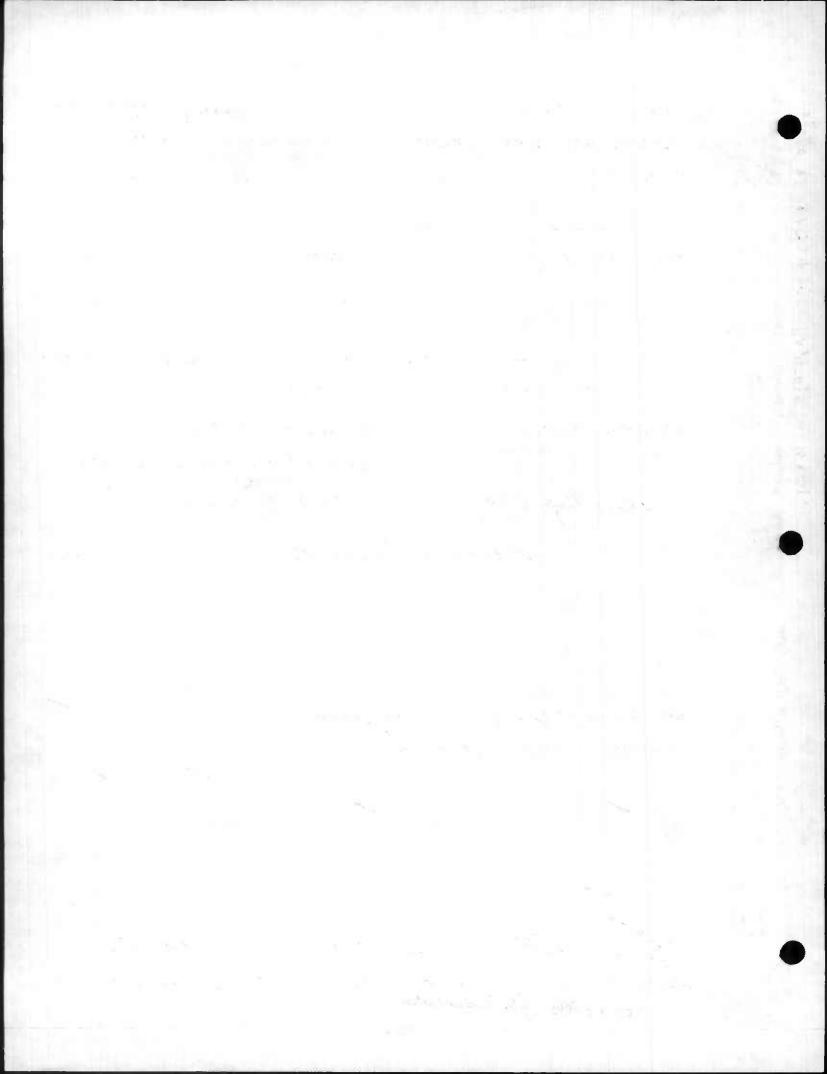
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			1. Decedent's Nar	me (First, Middla, Las	st)					2. Date of De	ath	Vana	3. Time of Death	
	п	Physician /Medical	Gov.	R. RA	eves					Month BERRY	Day A ~ 1 21,	Year 1998	0135	
		Examiner		(If not institution, give		per)			4b. City, Town, or L					
			PENINSU	JLA REGION	AL MEDIC	CAL CENT	ER		SALISBUT	RY	WICO	MICO		
		Funeral	5. Social Security	4		Age (In yrs. last	Mont	ths Days	if Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	th ay, Year)	9. Birtho	place (Stata or Foreign ntry)	
		Director	392-07-55	,0,	XM 2 F	86	Yrs.			July 2	5, 1911	Iot	wa	_
		pue *	Usual Residenca	10b. County	_	10c. City, To	own or Location					1	10d. Inside City Limits	-
		deny!	MD	WICOMICO		CA	TODITON						1 ☐ Yes 2 ☐ No	
		ith the Marylan or 28a-f show	10e. Street and No	1		SA.	LISBURY 10f.	. Zip Code			10g. Citizen of V	What Cour	ntry?	-
		23a or		DERICK AVE				210	0.1		7.7			
		firer death with the Maryland r items 23s or 28s-f show the must be notified at Funeral Director	11. Marital Status	DERICK AVE	12. Was Deced		13. Was Do	218 ecedent of F	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No)- 14. Rac		can indian,	-
	0			ried 2 Married	Armed Forc	⊡ -No		specify Cub		o Hicen, etc.)		ck, White,	etc.	
3	5-0020	o Fr.		4 ☐ Divorced	If Yes, Give Year or Date		1016	S 42C 140	эрвспу.		Specify		HITE	
300	5-0	ed within 72 hours ygiene. her than "natural", ft, the Wedes I Ex Completed by	(Spa	15. Decedent's Ed		1	6e. Decedent's U (Giva kind of	Jsual Occup work done	pation during most of work id)	king	16b. Kind of Bu	usiness/In	dustry	
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٦٠	aryland	Se se se												
5	7	d 2 should the and Men 7 is marke treumatic		REEVES			19b. Mailing Add	ress (Street	DORA HAY		er, Cify or Town,	Stata, Zir	o Coda)	-
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			23a. Part 1. Enter	the disease, or compart failure. List only	pilications that ceu	ised the death. [Do not enter the	mode of dyi	ng, such as cardiac	or respiretory	rrest,	MD Z	Approximate Interval Between	
		Physician	SHOCK, OF HE	art failule. List offiny	one cause on eac	at inte.							Onset and Death	
		/Medical	immediate Cause diseese or conditi	ion	D. O.	ugu	1, a							
	90	Examiner	resulting in death)	a. VIE		e consequence	of):				I		1
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		ficate be assecuted physician and so the burial-transit edical Examin	Sequentially list of if any, leading to it ceuse. Enter Und Cause (Disease of	onditions, immediate		Due to (or es	e consequence	of):				1		
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		death d for	Part II Other eign	ificant conditions of	ontributing to dea	th but not resultin	o in the underlyi	na causa ai	ven in Part I	23b. Did	tobacco use co	ntributa t	to the cause of death?	-
	P.0	The law requires that the death certifule has been signed by the attending page 2 should be datached for use a completed by Physiclan/M.	n				,				Yes 2□ No	3 Pro		1
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	ita	ysician: The law is certificate hes director, page 2 fo Be Comp	25. Was cese refe examiner?	erred to medical					26. Piace of Dea	th (Check only	one)			
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	n n	fler the unera	27. Manner of Dea	ath 5 ☐ Pending	28a. Dete of (Month,	Injury 28 Day Year)	b. Time of Injury	28c. Inju Wo		28d. Describe	how injury occur	red		
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		n 24 hound in 24 h	(Check only one)			is of examination			opinion, death occur					
		To the Hospital or Attending Physicians 24 hours after death. To the Funerel Director: After this completely filled in by the funeral dimensional medical Certification: To	29b. Signature an	d title of gertifier				29c. Licen:	se number		29d. Date signe	ed (Month,	Day, Year)	
4		- > - 0	▶ \(\)	1 (1, 4,				5 51	5674		2/2,	61		
		12	30. Name and add	fress of person who	mpleted ceuse	of death (Item 23	a) (Type, Print)				-10((/ /		
		12	580	och 5	n	120	Pine	~ de), Jal)	Jbn.	2. R	VZ	1804	
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		Registrar	FF	B 231998	Station	muller ha	dall							



		State of M	laryland / l		of Health and of Death		5	8 07230
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/Medical Examiner	Vernon 4e. Fecility Neme (If not institution	James , give street end number		Rathel	4b. City, Town, o	or Location of Deeth		y of Deeth
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Funeral	5. Sociel Security Number		ge (In yrs. lest bir	thdey) If Under	Year If Under 24 H	rs. 8. Dete of Birt	h	Birthplece (State or Foreig Country)
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Examiner must be notified at by Funeral Director	MD Wicom	ico	Sali	sbury				1 ☐ Yes 34 ☐ No
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r Items 23a direct must. Funeral	7911 Dublin Roa		=		21801	45		USA
or Item	11. Maritel Stetus	12. Wes Dacedent Armed Forces	?	13. Was Deced	ent of Hispenic Origin? fy Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Re Bie	ce - American Indien, eck, White, etc.
by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☑ Divorced	ed 1 Tes 2 If Yes, Give Yeer or Dates:	No	1□ Yes 🔏	No Specify:		Speci	^{ty:} White
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Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Entar Undartying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest	b	Due to (or es e	consequence of): consequence of):				
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be det	Oto frethe	worthy	, /	Cense fo	iline	_ ''	108 2 NO	3 Probably 4 Dikilos
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irector, page	25. Was case referred to medical				26. Plece of D	Deeth (Check only o		
To B	exeminer?	Hospitel:	ient 2 ☐ ER/Ou	tpetient 3 DO	Othor	Home 5 Resid		her (Specify)
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Direct in by	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	and 286. Piece of in	jury - At home, fe tc. (Specify)	rm, street, factory,	office	28f. Location (S City or Tow	Street end Num m, Stete)	ber or Rurel Route Number,
completely filled Medical Ce	29a. Cartifier 1 Certifying (Check only one)	Physician: To the bast examiner: On the basis of end menner s	of examinetion en	o, deeth occurred e d/or invastigation,	t the time, dete end pie in my opinion, daath oo	ce, end due to the c curred at tha tima,	ceuse(s) end m date and place	nenner as steted. , and due to the cause(s)
Me	29b. Signature and title of certifier	Sile individual		29c.	License number		29d. Dete sign	ed (Month, Dey, Year)
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DHMH 16 Rav 6/95

State Registrar

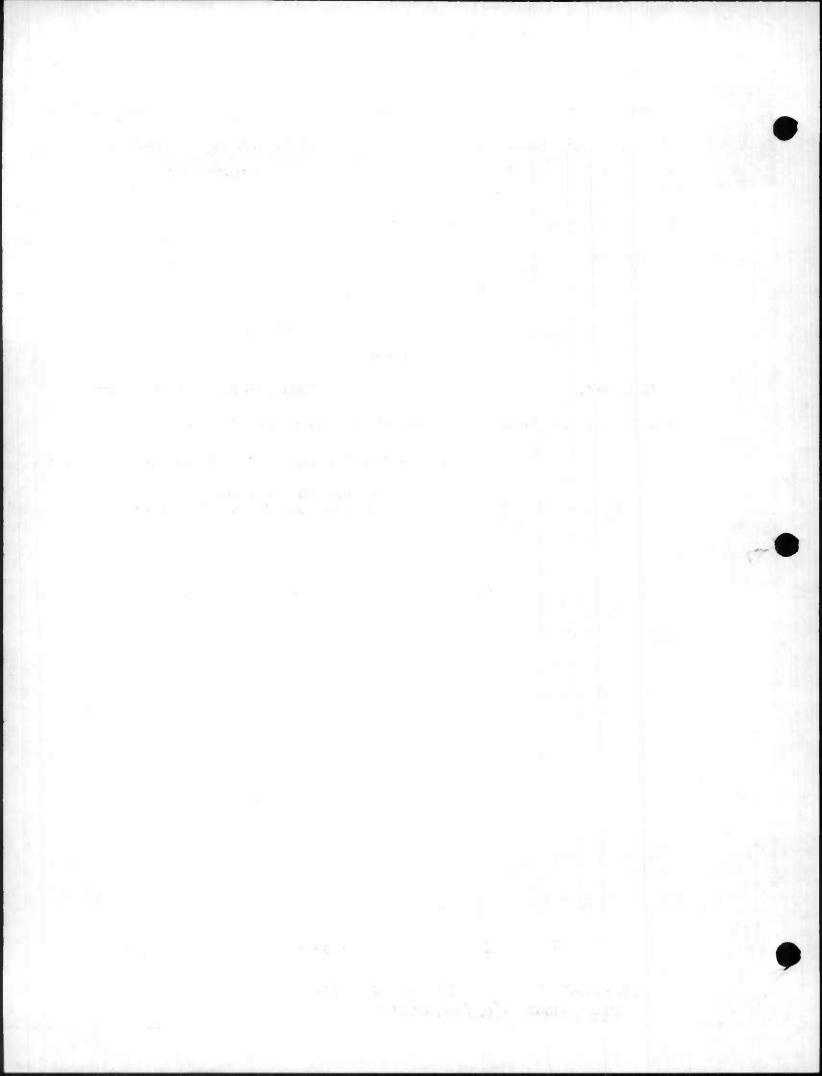


State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death **Physician** Month 1998 RAYFIELD Feb. 16, 9:25AM M. /Medical 4a. Facility Nama (If not institution, give street and numbar) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Salisbury Center Genesis ElderCare Wicomico Salisbury, Md. If Under 1 Year Months Days if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year, 10-22-1907 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funerai** 1□ M 2□XF Yrs. 90 Director 217-01-8098 Usual Rasidance of Decedent tha Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Madical Examiner must be notified at Yas 2 No Directo Md. Wicomico Sharptown 10e. Straat and Numbar 10f. Zip Coda 10g. Citizan of Whet Country? 404 4th St. 21861 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ② No If Yas, Give Yaar or Datas: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status filed within 72 hours after 1 Nevar Merried 2 Marriad Baltimore, Maryland 21215-0020 1 Yas 2 No Spacify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Dacedant's Education (Spacify only highest grade completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygians important: If Item 27 is marked other than any Injury or other traumetin. Elementary/Secondary (0-12) College (1-4or 5+) 11 Presser Garment Co. 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Meidan Sumama) William Boston Laura (maiden unknown) Bradley 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) Fred R. Rayfield, Husband 404 4th St. Sharptown, Md. 21861 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Mardela Memorial Cem. 2-18-98 Mardela Springs, Md. 21. Signature of Funaral Sarvice Licansea 22. Nama and Addrass of Fecility Short Funeral Home, Inc. 23a. Pert1. Entar the disaasa, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiretory arrast, shock, or heart deliure. List only one causa on each line. Approximate Interval Betw Onsat end Deeth **Physician →**Medicai Immadiata Causa (Final disaesa or condition rasulting in deeth) Examiner Tha law requires that the daath certificata be executed burial-transit Sequentially list conditions, if any, leading to Immadiate cause. Enter Undarlying Causa (Disaasa or injury that Initiated avants resulting in daath) Last and Box 68760. attanding physician for usa as tha buria Physician/Medical Due to (or as a consequence of): signed by the all Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed peen : has paga 2 cartificata 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this carifics 25. Wes casa rafarrad to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) P 1 Yas 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Matural 5 Panding 1 Yes 2 No invastigation 2 Accidant by the 3 Sulcida 6 Could not be detarmined 28f. Location (Straet and Number or Rural Routa Number, City or Town, Steta) 28e. Plece of Injury - At homa, farm, street, fectory, offica building, atc. (Spacify) 4 Homicida 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. Medicai 29a. Certifian completely 29b. Signatura and titla of certifian 29c. Licensa numbar 29d. Data signed (Month, Day, Yaar) D-29349 30. Name end eddrass of person who complated cause of daeth (Itam 23a) (Type, Print) WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD @:*)\$ 32. Degistrer's Signatura 31. Date filad (Month, Day, Year) State FEB 191998

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Registrar



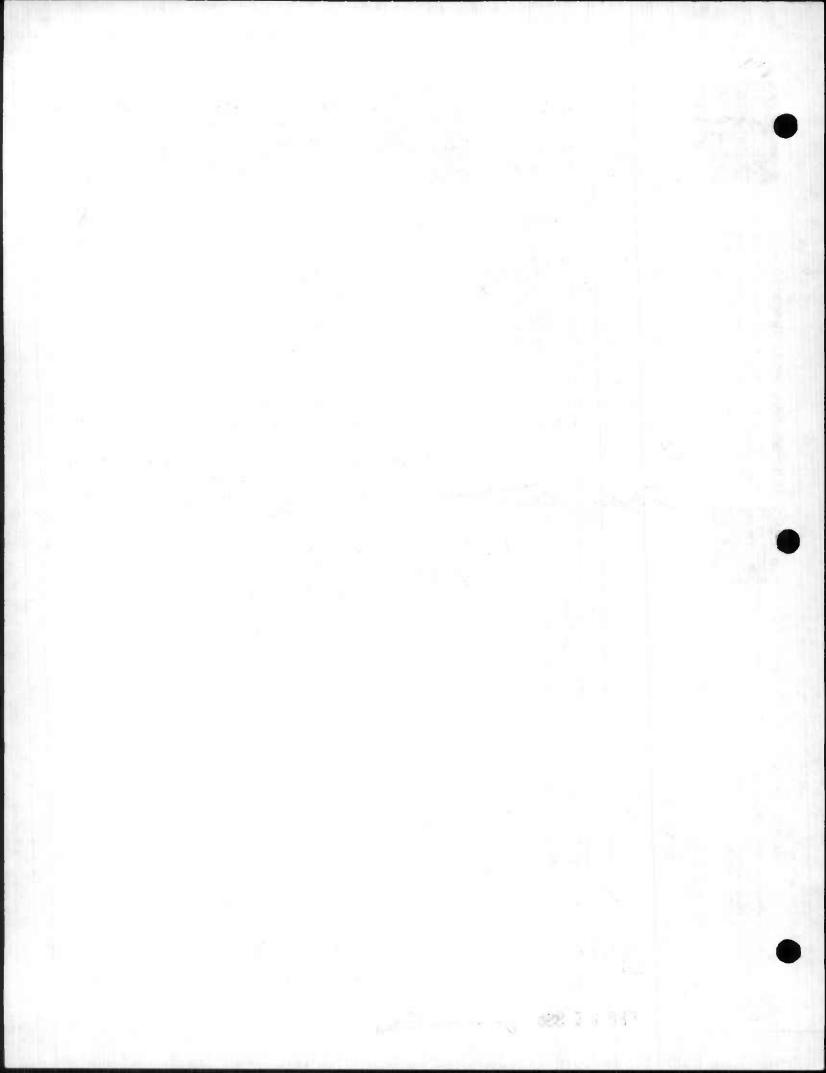
State of Maryland / Department of Health and Mental Hygiene Q

					,	Certificate of	Death	Rea	No.) (1232
	buoioi	an.	1. Decedent's Name (First, Middle, La	st)				2. Dete of Death Month	Dey	Year	3. Time of Death
	hysici /Medic	al	Naomi Frances 4a. Fecility Name (If not institution, give				4b. City, Town, or	February		998	5:15 PM
	xamin	ier			ı						
Fu	neral		Frederick Memori 5. Social Security Number 6. S	Sex 7. Age	(in yrs. last bir	thday) If Under 1 Yea			Frede		iace (Stete or Foreign
Dir	ector		213-22-2678 Usual Residence of Decedent	□M 2∏ F	72	Yrs. Months Deys	s Hours Mir	oct. 7,	1925	West	Virginia_
rylen	How I		10a. State 10b. County		10c. City, Tow	n or Location				10	0d. Inside City Limits
the Ma	28a-fa	Funeral Director	Md. Washing	ton	Knoxv	ille 10f. Zip Code		100	. Citizen of W	/het Coun	1 ☐ Yes 2 No
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deeth	E 5	Jera	11. Meritel Stetus	12. Wes Decedent Ex	ver in U,S.	13. Wes Decedent of If Yes, specify Cu		Specify Yes or No-		- America	
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Z1Z15-UUZU d within 72 hours of giene.	atura Esta		15. Decedent's Ed	ducation	16a.	Decedent's Usual Occu	upation	16	b. Kind of Bu	siness/Ind	
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d 212 filed with Hygiene.	첉	NO.	0			ousewife			Homema	ker	
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arylan should be	arke atic	2	Lorenzo Washing	ton Konne			Clari	ssa Mae Wh	etzel		
War 2 sho	Taum.		19a. Informent's Name/Relationship (. Meiling Address (Street					
C 76 6	other t		Otha H. Reed - H	usband	20h Piese o	19042 Mille Disposition (Name of	rs Avenu	e - Knoxvi	lle, M	D 217	/58
	or of		1 N Burial 2 ☐ Cremation 3 ☐		cemere	ry, cremetory or other pi	ece)				
altimore, mit. Peges 1 e pertment of Hea	Jury		4 Donation 5 Other (Specif	<u> </u>	Restha	ven Memoria	al Garden	s 2/23/98	Freder	rick,	Md.
Baltim permit. Peg Depertment	eny Injury or one		21. Signeture of Funeral Service Licer	/		22. Name and Add	Spencer F	uneral Hom	ne.		
			23a. Part1. Enter the diseese, or com shock, or heert failure. List only	Spinn		Harpers 1	erry, WV	25425-002	88		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one ceuse on each line	he deeth. Do	not enter the mode of dy	ring, such as cerdie	ec or respiratory errest	t,		Approximete Interval Between Onset end Deeth
Phys /Me	ician dicai		Immediate Ceuse (Final								
	niner		diseese or condition resulting in death)	· aplast							weeks
<u> </u>		ē		D	ue to (or es e	consequence of):					
The law requires that the death certificate be executed	physician end the burial-transit	Examiner	Sequentially list conditions	b	ue to (or as e	consequence of):				-	
, °			Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initleted events								
ficete be ex	nysic the bi	Physician/Medical	that initieted events resulting in death) Lest	C	ue to (or es e	consequence of):					
artific o	9 98	Me M									
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	igned by the a	ysic	Pert II. Other significant conditions of	ontributing to death but	not resulting In	the underlying cause g	iven in Pert I.	23b. Did tobs	cco use con	tribute to	the cause of death?
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dlug i	fune	to Lo	1 XNaturel 5 ☐ Pending	(Month, Day		njury W	ork? ☐ Yes 2 ☐ No	20d. Describe now	injury occurr	00	
l or Attending efter death.	y the	Certification:	3 Suicide 6 Could not be		v - At home, fa	rm, street, factory, office		28f. Location (Street	et end Numbe	er or Rure	l Route Number.
S Sept	din	er	4 Homicide	building, etc.	(Specify)			City or Town, S			
LIVISION O To the Hospital or Attending Ph within 24 hours effer death.	stely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exan	ysician: To the best of niner: On the basis of e	my knowledge	, death occurred at the t d/or investigation, in my	time, dete and plea opinion, deeth occ	e, and due to the ceu-	se(s) end ma e end plece, e	nner es st and due to	ated. the ceuse(s)
ithin	omble	M	29b. Signeture and title of certifier	end manner state	ou.	29c. Licer	nse number	29d	. Date signed	(Month. I	Day, Year)
¥ € ¾	- 8		A	0	0						
		-	Kathleen W	Stern M!			32073		2/201	48	
			30. Name and address of person who		ath (Item 23e)		Raine	wick, Md	2171	1.	
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrer		IFVI (IVE	Drural	NICK, I'M	2111	0	
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neral		5. Social Security Nu	imber 6. Se	ex , 7. Ag	e (In yrs. I	est birthdey)	If Under		If Under 24 Hrs.	8. Date of B	irth			ace (State or Foreig
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	Physician/	Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b.							. Did tobacco use contribute to the cause of death?					
1									1	Yes 2	No	3 Prob	ably 4 Unknow	
	2											24e. Wes en eutopsy 24b. Were autopsy tin		
	d by									240. 770	24e. Wes en eutopsy performed? 24b. Were autopsy tire evalleble prior to completion of ca			leble prior to
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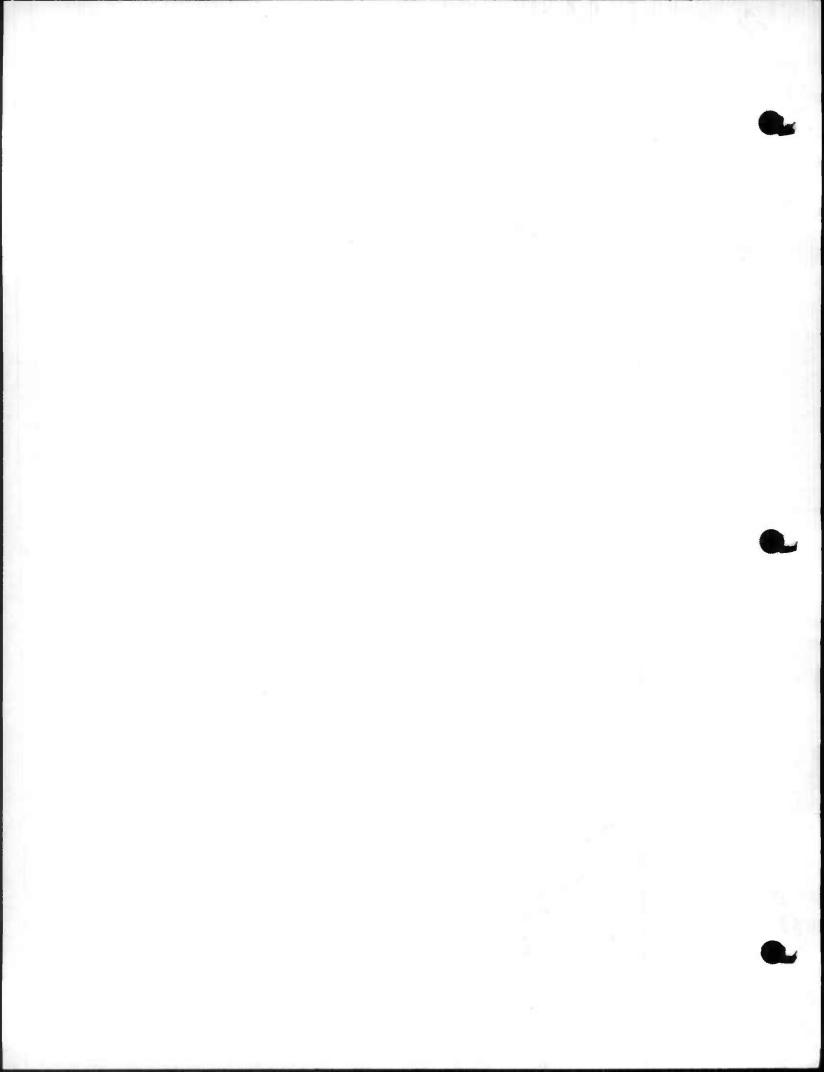
FOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		- STATE REGISTRAR		CF		ICATE OF		REG. N				
		1. DECEDENT'S NAME (First, Middle, Last)				IOAIL OI	DEATH	2. DATE OF DEATH	0.	3. TIME OF DEATH		
		Vida Koenig Sch					MONTH DAY YEAR					
		4. SOCIAL SECURITY NUMBER										
				6. AGE (In yrs. las		MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	- 1	BIRTHPLACE (State or Foreign Country)		
2		228-66-1208	1 🗌 M 2 🔀 F	74	YRS.			June 10,	1923	Yugoslavia		
should	-	Sa. FACILITY NAME (If not institution, give				9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNT	Y OF DEATH		
2, 3	CTOR	Goodwill Mennon	ite Home			Grant	sville		Garr	ett		
	5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT										
Pages	DIRE					Y, TOWN OR LOCA	ATION			10d. INSIDE CITY LIMITS?		
#			ngton		Ar	lington				t 🔀 YES 2 🗌 NO		
permit.	¥.	10e. STREET AND NUMBER				10	Of. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?		
nsit	1 5	4800 N. 20th St	reet				22207		Aus	tria		
215-0020 attending physician. se as the burial-transit	FUNER	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	MED			NIC ORIGIN? (Specify)				
9 £ 3		1 Never Merried 2 Merried	IF YES, GIVE WA	YES 2 N	10		pecify Cuben, Mexico S 2 🔯 NO Specia	en, Puerto Ricen, etc.)				
	B	3 Widowed 4 Divorced					J	,		white		
21.2 atten	0	15. DECEDENT'S EDI (Specify only highest gred	UCATION			USUAL OCCUPAT		16b. KIND OF B	USINESS/INDUS	STRY		
21 21 10 u	1 1	Elementary/Secondary (0-12)	College (1-4 or 5 +)	1Ho.	Do NOT us	vork done during m e retired.)	lost of working					
D Spira	1	3 rd			f-em	ployed		Day Ca	re Pro	vider		
YLAND 21215 by the hospital or attend be detached for use as	once.	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA	ME (First, Middle, Maide		120.02		
YL a	111	Anton Koenig					Anna	, , , , , , , , , , , , , , , , , , , ,		unknown)		
MARYLAND retained by the hospit 5 should be detached	00	19e. INFORMANT'S NAME (Type/Print)		198	MAILINO	ADDRESS (Street	and Number or Burel	Route Number, City or To				
A State	TO BI	Rosa K. Trucco/c	daughter									
Page 7	2	20a. METHOD OF DISPOSITION	daugnter			OF DISPOSITION /A		Dakland, M				
ALTIMORE death. Page 6 may tuneral director, pa	must	1X Buriel 2 Cremetion 3 Ren	noval from State	cemetery, crei	matory or of	her place)	lame of	27,98 Fa	OCATION — CIT	y or Town, State		
D age	-	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	CENCEE	Nation	al M	em. Par	k, Feb.	2/,98 Fa	ills Chi	urch, VA		
E de le	examiner	A A	1 D				ND ADDRESS OF FA		Dλ	P.O. Box 275		
BALTIMORE, er death. Page 6 may by the funeral director, page val.		N. Lynn	I pun	an								
af A	medical	23. PART i. Enter the dispases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.										
3	E	snock, or heart failure.	List Dnly one cous	e Dn each line.						interval Between		
24 € PO	흝	iMMEDIATE CAUSE (Final disease or condition	STI	ROKE	e					Onset and Death		
ted within 24 completely fille	event,	resulting in death)	a. DUE TO (OR AS A CONSEC	_	3.				3 weeks		
6876C executed with and complet b burial, cren			300 10 (0	ON NO N CONSEC	DENCE OF	.).						
executed and composite to burial,	ry, or other traumatic	Sequentially list conditions,	b. DUE TO (C	OR AS A CONSEC	HENCE OF	D.				-		
o dia o	AT	if any, leading to immediata cause. Enter UNDERLYING		A CONDEC	OENCE OF	<i>j.</i>						
2 2 2	TIFIC	CAUSE (Disease or Injury	C. DUE TO (C	OR AS A CONSEC	HIENCE OF	ā.						
O.O. O. O. Hygier Hygier	티튜	that initiated events resulting in death) LAST	502.10 (0	on no n consec	OENCE OF	<i>y</i> -						
S, P.O death certi attending ental Hygie	5 E		d									
0 0 0	any Injury,	PART II Other significant condition	ns contributing to d	leath but not re	eaulting (n the underlyin	ng cause given in	Part I. 24s. WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS		
E E E	amy Inju	bornestia						PERF	ORMED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE		
CO lines the signed tealth	1 1							1 YES	2 NO	OF DEATH?		
w requires been sign of. of Heat	shows : ME	DID TORACCO LISE CONT	DIBLITE TO CALL	ICE OF DEAT	FIL ME	C C NO F				1 _ YES 2 _ NO		
law law	A N	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAU					и 🗆 📗 📗				
I OF VITAL PHYSICIAN: The law this certificate has with the State Dep	ed, or item 23 shows PHYSICIAN: ME	EXAMINER?	HOSPITAL:			H (Check only one,)					
SICIAN: The certificate It the State	YS	t TYES 2 THE NO	1 Inpatient 2	ER/Outpetient 3	□ DOA	4 (Nursing Hor	ne 5 🗆 Reeldence	6 Other (Specify)				
OF PHYSIC this ce with th	P E	27. MANNER OF DEATH	26e. DATE OF IN (Month, Day)		26b. TIMI INJI		JURY AT ORK?	26d. DESCRIBE HOW	INJURY OCCUP	RED		
ON ONG P	marked BY PI	1 Natural 5 Pending 2 Accident Investigation				M 1 🗆	YES 2 NO					
VISION ATTENDING ECTOR: After s after death	<u>∞</u> □	3 Suicide 6 Could not be	26e. PLACE OF building, et	INJURY — At hor	ne, farm, a	treet, fectory, offic	ce	26f. LOCATION (Street end Number or Rural Route Number, City or Town, Stete)				
DIVISION DR ATTENDING F DIRECTOR: After hours after death	7E 78	4 Homicide determined						ony or rown, order	0)			
DIV DIREC	COMPLET	200. CERTIFIER (Check only 1 CERTIFYING PHYS	SICIAN: To the best of m	v knowledge, des	ith occurre	d at the time date	e and place, and due	to the cause(s) and m	enner ee steted			
PITAL PAL	¥									euse(e) and menner ee stated.		
TO THE HOSPITAL TO THE FUNERAL De filed within 72 is	N N		4	1	/)						
THE OT THE DE filed	E H	296. SIGNATURE AND TITLE OF CERTIFIE	· /)	1	(/		29c. LICENSE NUI		29d. DATE S	IGNED (Morith, Day, Year)		
223	2						100	4079	P 1-€	B 25 1998		
5	-	30. NAME AND ADDRESS OF PERSON WI	7 (.)	OF DEATH TEN	1 27) (Type,		1	1 -	_			
MIL			= 100	tuxi	3	(4)	mantsuil	le mo	di	536		
, - 0		31. DATE FILED (Month, Day, Year)	32. REGISTRAR	'S SIGNATURE								
		FFR 7. / 1000		450								

DHMH-16 Rev 1/89



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

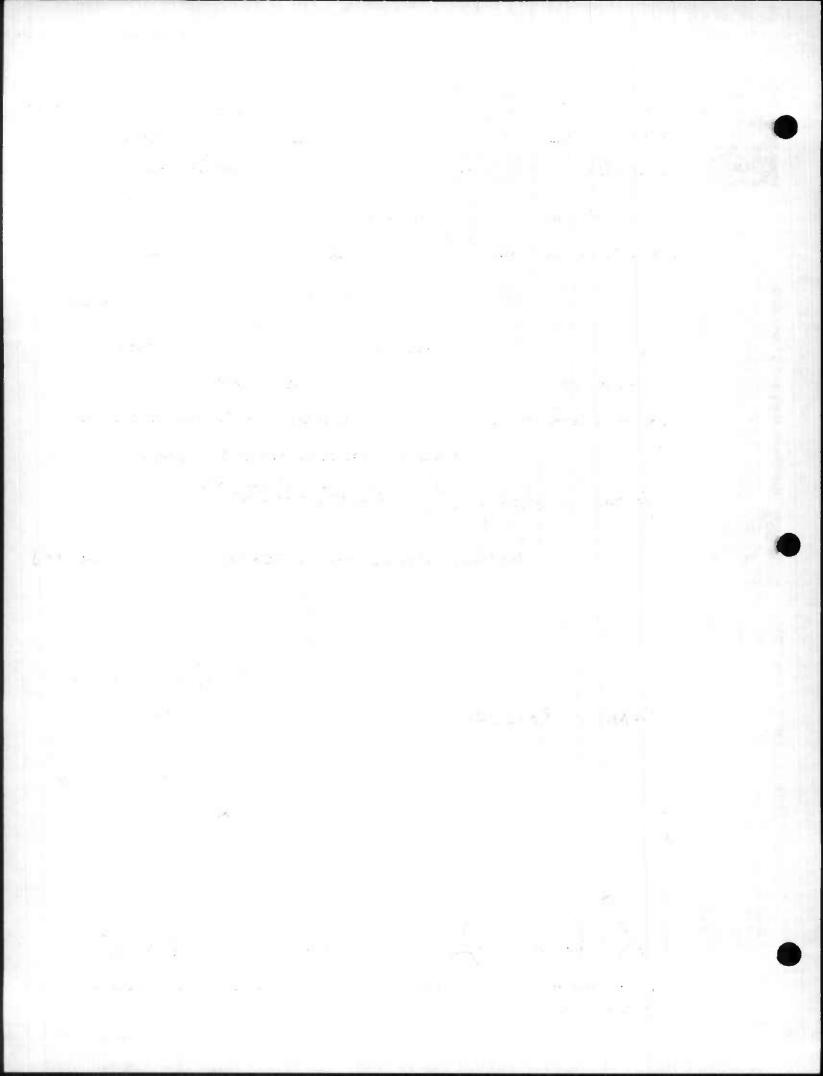
Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Year 4:00 pm Meriam Snyder 25, 1998 Feb /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 113 W. Industrial Blvd. Cumberland Allegany 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. Data of Birth (Month, Ben Year 1920 9. Birthplaca (Stata or Foreign Cpyntry) **Funeral** 10 M 2 F Days Hours 77 211-18-1100 Yrs. Director Usuel Rasidanca of Decadent the Marylend 10a Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryle Department of Health end Mantal Hygiens. Department of Health end Maryle Throoftant: it flem 27 is marked other than "natural; or flems 23s or 28e-f show any injury or other traumatic event, the leader Examine must be mortified as Allegany Cumberland MD 1 Yas 2 □ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 113 W. Industrial Blvd. USA 21502 Completed by Funeral 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Navar Married 2 Marriad 21215-0020 1 Yas 2 No Specify white 3℃ Widowed 4 Divorced 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be Walter Wilhelm Daisy (Robb) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 113 W. Industrial Blvd. Cumberland MD 21502 Linda K. Giles-daughter 20a. Method of Disposition

1 Buriel 2 Cremation 3 Ramoval from Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Restlawn Memorial Gardens 02/28 LaVale MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvica Licanses Scarpellin Fulleral Home, P.A. Cumberland MD 21502 23a. Part. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Cause (Final MITRAL VALVULAR DISEASE 20 YR1 disaasa or condition rasulting in daath) Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the ettending physician and the buriel-transit Sequentially list conditions, if eny, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequanca of) is certificate has been signed by the ettendin director, page 2 should be deteched for use 25,1998 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23th Did tobacco use contributs to the cause of death? 1 Yes No 3 Probably 4 Unknown FAILURE Be Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No this certificate 1 Yas 2 No 25. Was casa rafarred to medical 26. Place of Death (Check only one) examinar? 1 Yas 2 No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Home 5 ☐ Residanca 6 ☐ Othar (Specify) Certification: To In by the funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Daath 28c. Injury at Work? 28b. Tima of 28d. Dascribe how Injury occurred 1 Natural 5 Panding 2 Accident 1 ☐ Yas 2 ☐ No Invastigation 6 Could not be datamined 3 Sulcide 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicida completely filled 12 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian Medical (Check only one) 29b. Signature and title of conflic 29c. Licansa number 29d. Data signed (Month, Day, Yaar) D 14865 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nus Memorial Hosp. Medical Bldg. Cumberland MD Dr. Robustiano Barrera 31. Data filed (Month, Day, Year) FEB 27 1998 32. Registrar's Signatura State والمنادات والمنافقة فتافيا Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death **Physician** FEBRUARY 24 09:50A CATHERINE SHE SMITH /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **HEART** SACRED HOSPITAL CUMBERLAND ALLEGANY If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) MAR. 4,1916 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Months Days Hours 1□ M 20 F WEST VIRGINIA 81 Vrs 233-98-6190 Usual Rasidanca of Dacedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits MD Director ALLEGANY Yas 2□No CUMBERLAND 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? 131 ARCH STREET 21502 U.S.A. Funeral 12. Was Dacadant Evar In U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status Black Whita, atc. 1 ☐ Yas 2 🔯 No If Yas, Giva Yaar or Datas: 1 □ Navar Married 2 □ Married 1 ☐ Yas 2 ☑ No þ Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decadant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Etamantary/Secondary (0-12) Collaga (1-4or 5+) HOMEMAKER HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be EFFENGER BEAN MAGGIE POPE 0 19a. Informant's Name/Raiationship (Typa, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) ROSE SPOOLER / DAUGHTER 1038 SHADES LANE, CUMBERLAND, MD 21502 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Specify) ST. MARY'S CEMETERY 2/27/98 KESSELL, 21. Signature of Funaral Sarvice Licensas 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immadiata Causa (Final disaasa or condition rasulting in daath) KITIS Dua to (or as a consequence of) Physician/Medical Examiner 10 DAY Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated evants rasulting In death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy 1 ☐ Yas 2 ☐ No CEREBOURSCULAR DECAS 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 2☐ ER/Outpatiant 3☐ DOA Othar: 4 Nursing Homa 5 Residence 8 Other (Specify) Certification: To 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 1 SNaturai 5 Panding invastigation 1 TYas 2 No 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homleida Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Cartifiar edical (Check only one)

29c. Licansa number

902 Seton Drive #308, Cumberland, MD 21502

29d. Data signed (Month, Day, Year)

FEBRUARY 24,1998

The law requires that the death certificate be executed ed by the detached Records, P.O. Division of Vital or Attending Physician: After this funeral death. the 24 hours after deatl Funeral Director: filled in by Hospital completely

Funeral

Director

28a-f show

6 238

ltems :

permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examina

Physician /Medicai

Examiner

physician and s the burial-transit

as for use

Box 68760.

Baltimore, Maryland 21215-0020

traumatic event, the Medical Examiner must be notified at

the Marylend

death

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State Registrar 29b. Signatura and Mia of certifian

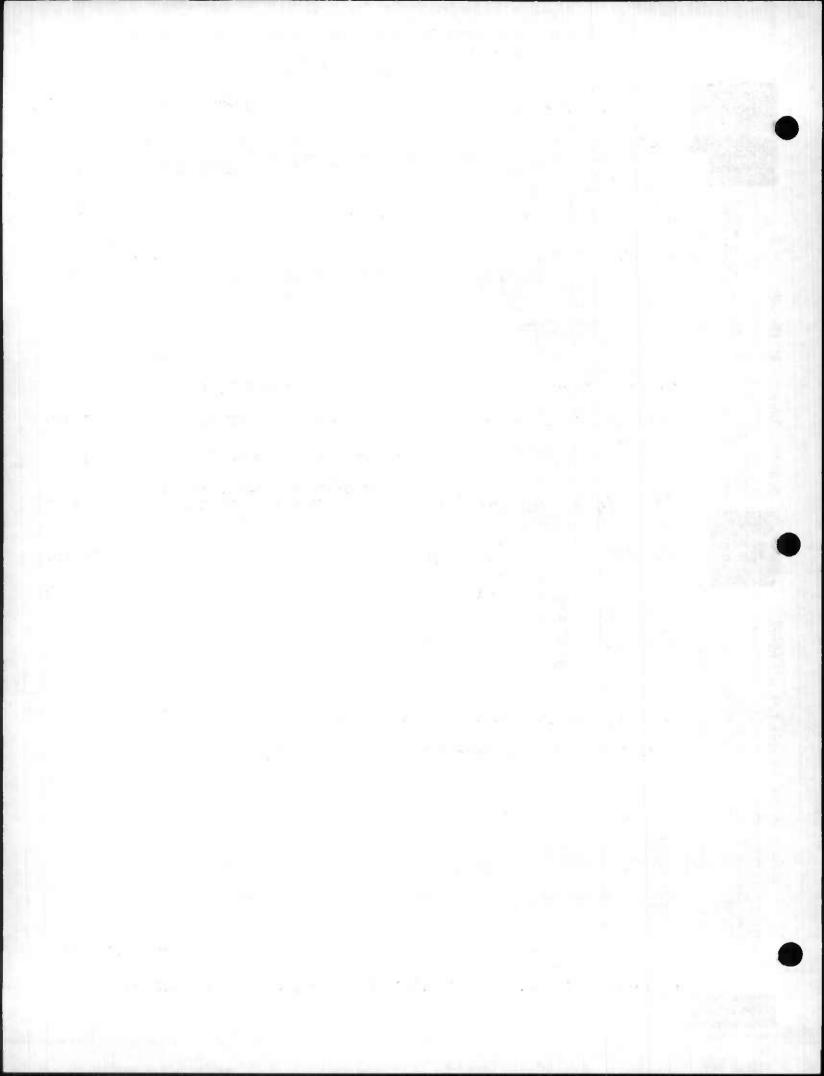
30. Nama and addrass of person.

Robert A. Welik, MD.

WACKT

wito complated causa of death (Item 23a) (Type, Print)

132 Fingistrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month Yaar Frances G. 4b. City, Town, or Location of Deeth 4c. County of Death Slagle 030ZA /Medical 4a. Fecility Neme (If not institution, give streat and number) 4c. County of Death Examiner Gilcrest Hospice Center Baltimore Baltimore | Houndar 1 Year | Houndar 24 Hrs. | 8. Deta of Birth (Month, Day, Year) | Sept. 5, 1936 5. Social Security Number 9. Birthpleca (Stata or Foreign Country) Tennessee 7. Age (In yrs. last birthday) **Funeral** 1□M 2♥F 411-54-6396 61 Yrs Director Usual Rasidance of Dacedant with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Manyan Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or frems 23a or 28a-f show any injury or other traumatic event, the Medical Examines must be notified at Maryland Howard Woodbine Director 1 ☐ Yas 2 No 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 17767 Annapolis Rock Road 21791 American Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Give Year or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 □ Navar Married 2 □ Married FRANCIS SLAGLE Baltimore, Maryland 21215-0020 White 1 Yas 2 No Specify: þ 3 ₩ Widowed 4 Divorcad Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grade complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) County Schools Bus Driver 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Nola Mae Buchanan Thomas Lloyd 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 160 Woodland Court, Charles Town, West Virginia Brenda Denney - Daughter 20b. Placa of Disposition (Nama of camatary, crematory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 DBurial 2 Cramation 3 Ramoval from Stata 2/21/98 Flagg Pond, Tennessee Edwards Branch Cemetery 4 Donation 5 Othar (Specify) 21. Signature of Funaral 22. Nama and Addrass of Facility Olin L. Molesworth, P.A., Funeral Home 23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or hear failure. List only one cause on each line. 20872 Approximata Intarval Batwaan **Physician** /Medicai of unknown primary Immediata Causa (Final Adenocarcinoma 8 musta disease or condition rasulting in daath) Examiner Dua to (or as a consequence of) buriet-trensit Sequantially list conditions, if eny, laading to immadieta cause. Enter Underlying Causa (Disaasa or Injury that Initiated evants rasulting in daath) Last and Dua to (or as e consequence of): physician s s the buriet Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ 24b. Wara autopsy findings aveilebla prior to Completed 24a. Was an autopsy performed? been completion of cause of death? 1 ☐ Yas 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice Be 25. Was casa rafarred to medicat 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 1 ☐ Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funerat 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yas 2 No 2 Accidant Invastigation 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) E O 4 - Homicida TC Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medicai 29b. Signature end titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) mo 30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) BMC (70 r N. Charles St Balto, md Zizox
32. Registrar's Signatura IBMC 0 31. Dete filed (Month, Day, Year) State Jalia Studeon Rawlatt Registrar

DHMH 16 Ray 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Frelyn Smith Month 853 AM lascher Fel 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia . Howard 5. Sociei Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 22,1905
Birthplaca (Stata or For Country)
Significant State of For Country) 6. Sex 7. Age (In yrs. last birthdey) Birthplaca (Stata or Foreign Country) Deys 1□M 2🗗F Hours 579-64-8041 Yrs. 92 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 6336 Cedar Lane 347 21044 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2≦ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🛣 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Housewife Domestic 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumema) Charles F. LeMenager Emma Bernard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 9410 Wandering Way, Columbia, Md. 21045 Allan K. Tascher 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Melhod of Disposition Dete 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Monocacy Cemetery 2/17 Beallsville, Md. 21. Signeture of Funeral Service Lioupsee 22. Name and Address of Fecility Hilton Funeral Home Box 86 Barnesville, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) remuns Sequentially list conditions, if any, teading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Physician /Medical Examiner burial-transit The law requires thet the death certificete be executed

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been signed by should be detec

page 2

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

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Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Director

ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other treumatic event, the Modical Examinal must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mentei Hygiene. If them 27 is merked other than "natural", or flen any Injury or other treumatic event

Baltimore, Maryland 21215-0020

death with the Meryland

Examiner Physiclan/Medical by Be Completed

Medical Certification: To 27. Manner of Deeth

1 inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of

28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Spacify)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature end title of contifier

29a. Certifier

1 Naturai

2 Accident 3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

AL Columbia, MO

FEB 1 8 1998

5 Pending investigation

6 Could not be determined

D-34868

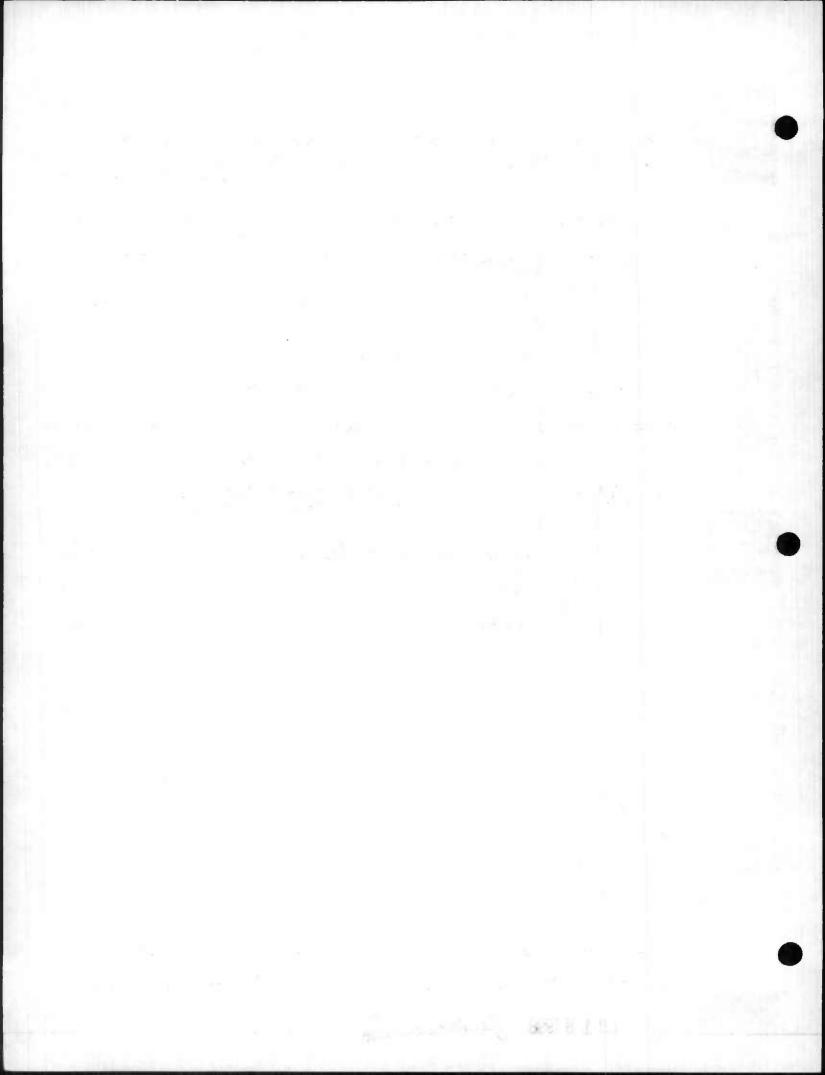
30. Name end eddress of person who completed cause of death (ttem 23a) (Type, Print) Littes Proupont

Dionen 31. Date filed (Month, Day, Year)



State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month February 14, 1998 6:24 AM Stalev 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Memorial Hospital ital Frederick 7. Aga (In yrs. last birthday) | H Undar 1 Year | H Undar 24 Hrs. | Frederick 5. Social Security Number 8. Data of Birth (Month, Day, Year) 1∭ M 2□ F Days Hours Yrs. 215-26-1759 July 13, 1917 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☑ Yas 2 ☐ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1003 Rosemont Avenue 21701 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ⊠ Yes 2 □ No If Yas, Giva Year or Dates: ₩₩II 11 Marital Status 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian. Black, White, etc. 1 ☐ Never Married 2 X Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grada completed) College (1-4or 5+) Elementary/Secondery (0-12) 3 Farm Manager Farming/Agriculture 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Melden Surneme) Vernon L. Sanner Estella B. Staley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Ruby S. Sanner, wife 1003 Rosemont Ave., Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removal from State 4 Donation 5 Other (Specify) Mt. Olivet Cemetery 2/17/98 Frederick, Maryland 22. Nama and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Entir the disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each inn. Approximete Interval Between Onsat and Death Thoracia Aortic Annyan Shours Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 11/96 CVA 1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only one)

Physician /Medical Examiner requires that the death cartificeta be executed

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after to Department of Haalb and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Item eny Injury or other traumatic event, the Medical Examinations.

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records,

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ettending physician and for usa as the burial-transit Physician/Medical signed b þ Completed cartificata To the Hospital or Attending Physician: within 24 hours effar death.

To the Funeral Director: Affer this cartifica complataly filled in by the funaral director, I Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury thet initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. Ascending Thorocec Autic Aneuryon 15 month CORDNARY ARTERY DISGATE 25. Was case referred to medical examiner?

1 Yes 2 No Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Tima of 1 Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 29c. Licanse numbar 29b. Signature and title of certifier

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MIL

29d. Data signed (Month, Day, Year)

Frederick, Md 21701

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) 300 W.

Grisson Mh 31. Date filed (Month, Dey, Year) 32. Registrar's Signature

State Registrar

DHMH 16 Rev 6/95



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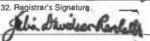
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aminer	4a Facility Nama (If not institution, give	e street and number)			4b. City, Town, or Lo	ocation of Death	4c. County	of Death	
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al	5. Social Sacurity Number 6. S	ax 7. Aga (In y	rs. last birthday)	If Under 1 Yaa Months Days		8. Data of Birth (Month, Day June 10	Year)	9. Birthplace (S Country) Marylar	Stata or Foraign
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Directo	10e. Street and Number			10f. Zip Code			IOg. Citizen of V	Vhat Country?	
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To	Andrew H. Smi	th			Elsie		merman		20070
	19a. Informant's Name/Ralationship (Type, Print)	19b. Maili	ng Addrass (Strae	at and Number or Rur	al Route Numbe	r, City or Town,	Stata, Zip Coda,	208/2
	Joyce A. Smith -		950	0 Pleasa	nt Plains	Court,	Damascu	s, Mary	Land
e e	20a. Mathod of Disposition		complete at oron	osition (Nama of matory or other pl	aca)	Data		City or Town, St	
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cian dical niner	23a. Part1. Entar the diseasa, or comshock, or haart failure. List only Immediate Causa (Finel diseasa or condition rasulting in death)	Dications that causad that dona ceuse on each line.	aath. Do not an	tar tha moda of dy	ge Road, D	or raspiretory er	, Maryl	Appro	872-0117 eximate ral Batween it end Death ys sells whis
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To Be Com	25. Was case refarred to medical				26. Placa of Deal	th (Check only o	ne)		
ToB	axaminar? 1 ☐ Yas	Hospital: Inpatiant 2	□ ER/Outpatle	nt 3 DOA	thar: 4 Nursing Ho	oma 5 Rasio	lanca 6 Oth	ar (Specify)	
	27. Mannar of Death 1 Natural 5 Panding 2 Accidant Invastigation	28a. Date of Injury (Month, Day Year	28b. Time o	g 28c. Inj			now injury occur		
but Director: After the din by the funerated in by the funerated in Certification:	3 Sulcide 6 Could not be datarmined	28a. Placa of Injury - A building, atc. (Spi	t home, farm, st acify)	raet, factory, office	9	28f. Location (\$ City or Tox		per or Rural Rout	ta Number,
pletely fill edical		ysician: To the best of my inner: On the basis of exem and mannar statad.							ausa(s)
E Z	29b. Signatura and titla of cartifiar			29c. Lice	nse number		29d. Data signe	d (Month, Day, 1	Year)

State Registrar

Doubles R.
31. Data filed (Month, Day, Year)

Druglad Plecenter in



30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) 615 W. MOST 60, SRY 908

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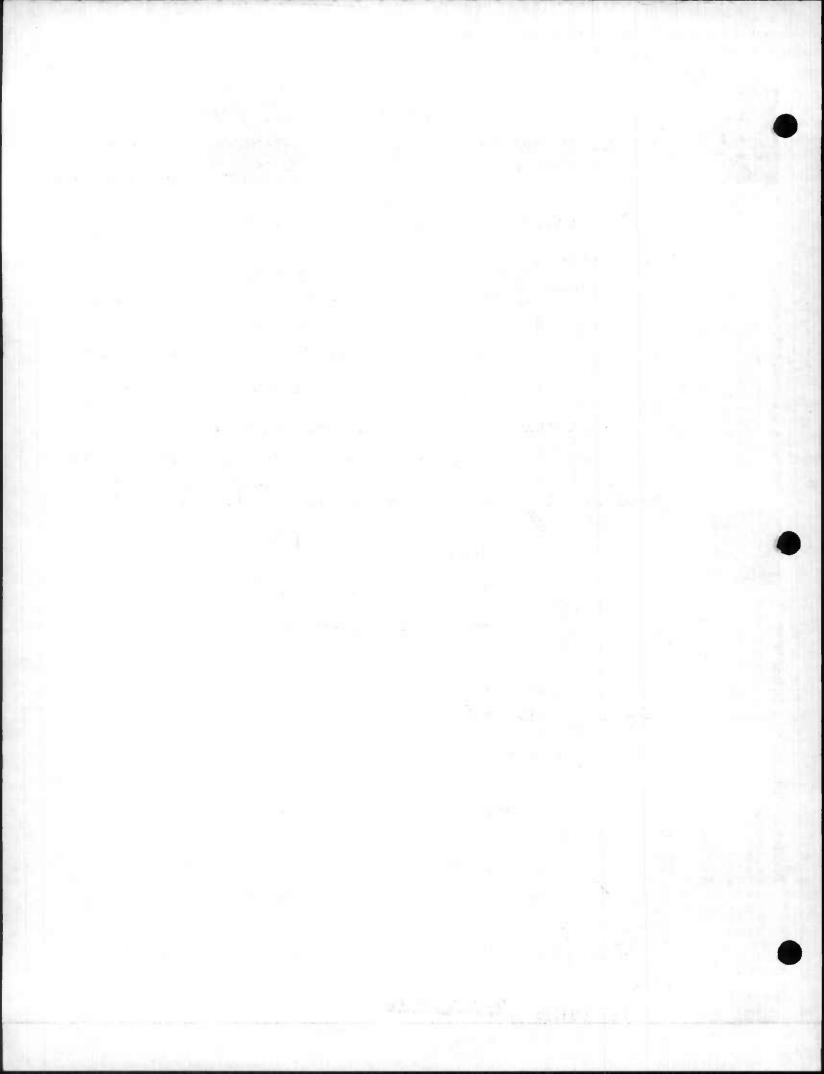
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State of Maryland / Department of Health and Mental Hygiene 98 0724

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Russell 20 Foburry 4a Facility Name (If not institution, give street and number) 98 2AM 4b. City, Town, or Location of Death 4c. County of Death Baltimore Kerslers/ Cheery weed 5. Social Security Rumber Manor If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dav. Year) Birthplace (State or Foreign Country) 1 M 2 □ F Months Days Hours Min Yrs. 221-03-2439 88 6-10-1909 Md. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yee 2X No Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15635 Dover Road 21155 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian. 11. Maritai Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dales: 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Painter Dupont Nylon Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Larry W. Truitt Lovey Foskey Truitt 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15635 Dover Rd., Upperco, Md. 21155 Marsha T. Schuster, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stephens Cemetery 2-22-98 Delmar, De. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Short Funeral Home, Inc. Short Hannigan 13 E. Grove St. Delmar, De. 19940 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No one End Storme Parhim 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? CHF, CAD, COPD 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23 a or 28=4 ahow any Insportant: If item 23 a or 28=4 ahow any Insportant: If item 27 and 1 and

Baltimore, Maryland 21215-0020

Physician/Medical Examiner physician and s the burial-transit USB BS attending p ed by the a signed by to δ Completed peed ata has t Be

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Certification:

The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, cartificata or Attending Physician: After this c within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

edicai within 2 State

Registrar

25. Was cese referred to medical examiner? Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier

1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) end menner as stated.

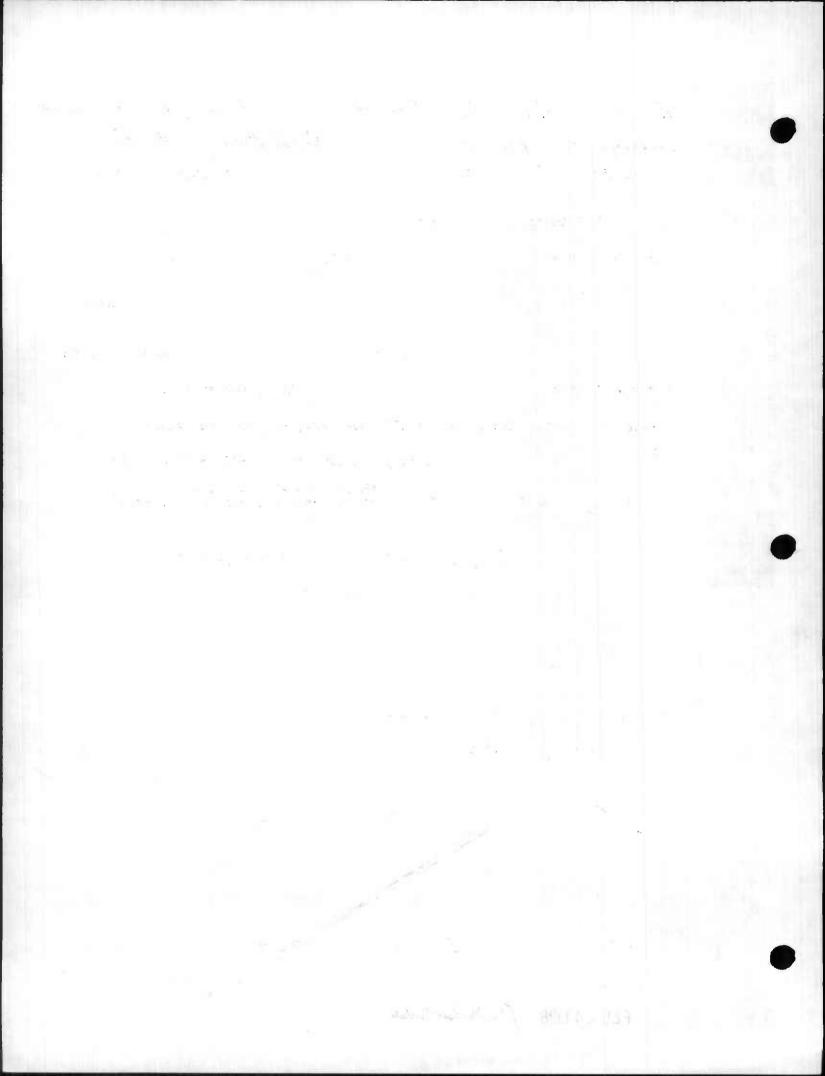
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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30. Name and address of person who completed ceue death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) 32. Registrar's Signature alis Studen Rardell FEB 241998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month JANE TRUITT FEBRUARY 20 1998 2:55 pm /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner BERLIN NURSING & REHABILITATION CENTER BERLIN WORCESTER If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) **Funeral** 9. Birthplece (State or Foreign 1 M 2 F Months Deys Yrs. Director 78 217-03-6000 SEPT. 9, 1919 MARYLAND Usuel Residence of Decaden the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or itema 23a or 28a-f show the Madical Examiner must be notified at Director 1 Yes 2 No WORCESTER MARYLAND BISHOPVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? or itema 23a or 10028 BISHOPVILLE ROAD 21813 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or its any injury or other traumatic event, the Medical Examina any injury or other traumatic event, the Medical Examina 2008. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Yes, Give 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Year or Detes: WHITE Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) **SEAMSTRESS** CLOTHING 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be JOSEPH TAYLOR ESSIE LEWIS 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) DAVID A. TRUITT RR 3, BOX W4A2, MILLSBORO, DELAWARE 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) NEW HOPE CEMETERY 2/23/98 WILLARDS, MARYLAND 21. Signature of Funeral S rvice Lices 22. Neme end Address of Fecility TRA HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 HASTINGS FUNERAL HUME, SELIDITION FUNERAL HUME Approximate Intervel Between Onset end Deeth **Physiclan** CANCER OF LONG (METASTATIC Immediate Cause (Final disease or condition resulting in deeth) /Medical **Examiner** Due to (or es e consequence of): Examiner mpay serup sician end buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760, Physician/Medical the Due to (or es e consequence of): 98 0 is certificate has been signed by the edirector, page 2 should be deteched in Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, þ Completed 24b. Were autopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? this certificate hes 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 | Inpatient 2 | ER/Outpetlent 3 | DOA luneral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 5 Pending Investigation 1 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homloide 1 XX-ertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated. Medical 29a. Certifier completely 29b. Signeture and title of certifier 29c, License number 746257 29d. Dete signed (Month, Dipr. Year) 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) EDWIN CASTANEDA 314 FRANKLIN AVENUE, BERLIN, MD 21811 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

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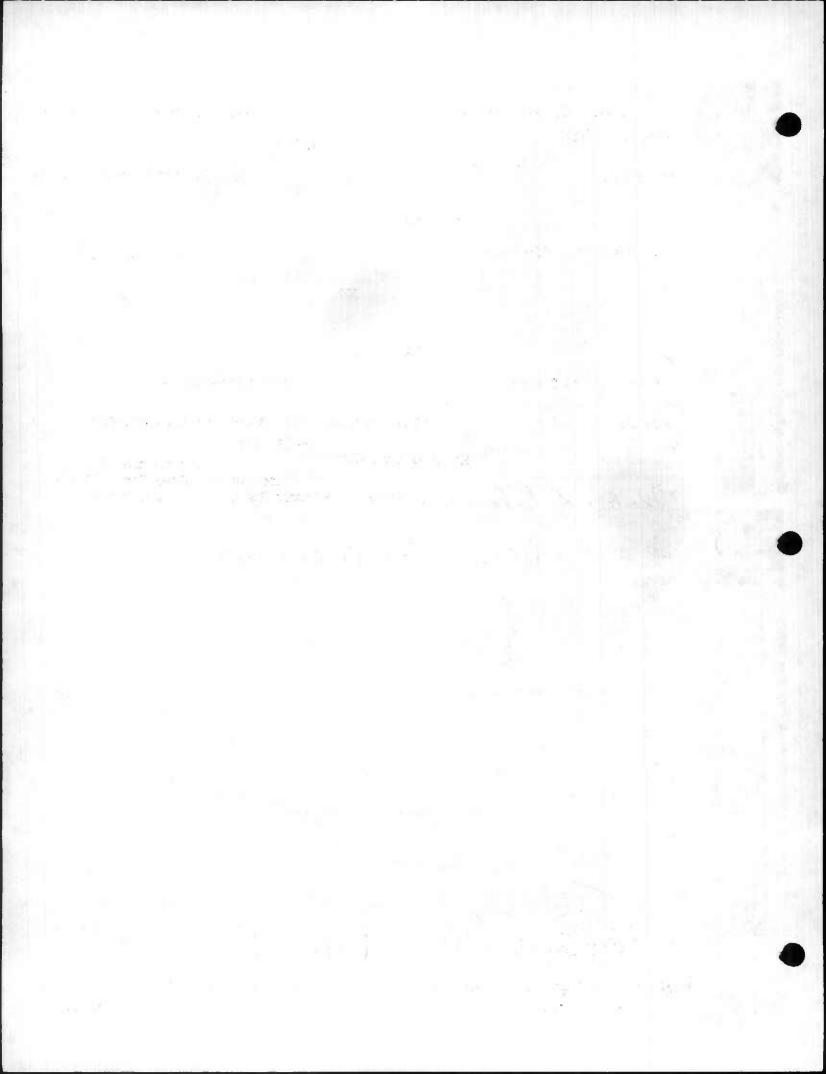
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FEB 23 1998

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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Frances Tusing February Ethel 13, 1998 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick
If Under 24 Hrs. 8
Hours Min. Frederick If Under 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplece (Stata or Foreign Country) 1 M 2 X F Months Days Yrs. 235-32-0725 July 19, 1924 West Virginia Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No W. Va. Jefferson Bolivar 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? 1164 Washington Street 25425 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 D No If Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Director County Agency 17. Fether's Nema (First, Middla, Last) 18. Mother's Neme (First, Middla, Maiden Surname) Harry Thornton Longerbeam Ethel Marie Staubs 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) P. O. Box 519 - Shepherdstown, WV 25443 Charles D. Tusing, Son 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Steta Date 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donetion 5 Other (Spacify) Fairview Lutheran Cemetery 2/17/98 Bolivar, W. Va. 21. Signature of Funaral Sarvice Licensae 22. Nama and Addrass of Facility Eackles-Spencer Funeral Home Harpers Ferry, WV 25425-0028 Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onset end Death Immediete Causa (Final Can Con. diseasa or condition rasulting in death) Dua to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be 2 10a. Stata

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show supinjury or other treumstic event, the Medical Examinat must be notified at some.

Baltimore, Maryland 21215-0020

niner physician end s the burial-transit ettending ph been signed by the e cate hes l To the Hospital or Attending Physician: within 24 hours after death.

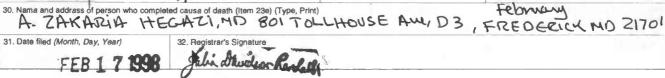
To the Funeral Director: After this certifica completely filled in by the funeral director; p

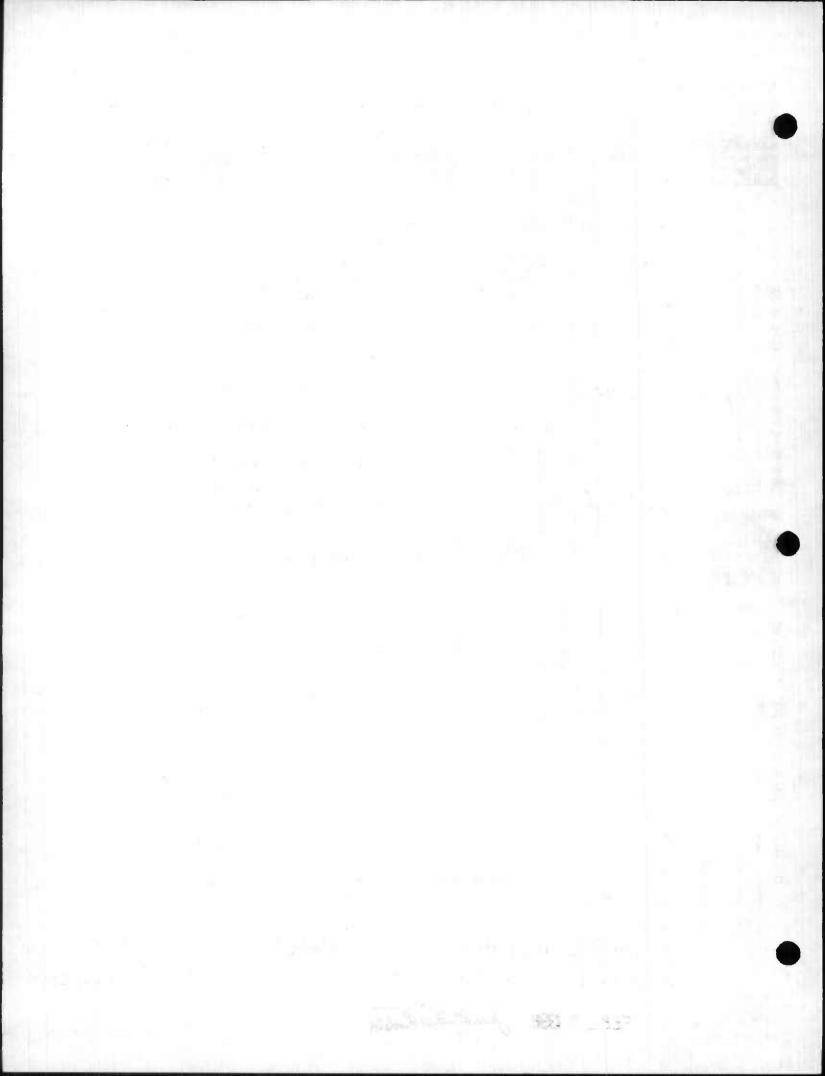
Division of Vital Records, P.O. Box 68760

Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disaase or Injury	Dua to (or as a consequance of):			
that initiated events rasulting in deeth) Last	Due to (or as a consequance of):			
Causa (Disaasa or Injury that initiated events trasulting in deeth) Last Part II. Other significant conditions of	ontributing to death but not re	sulting In tha undarlying c	ausa givan in Part I.	23b. Did tobacco uae co 1 X Yes 2 □ No	intribute to the cause of death?
				24a. Was en autopsy performed?	24b. Wara autopsy findings available prior to complation of cause of daeth?
25. Was case rafarred to medical axaminar?			28 Place of D	aath (Check only ona)	TIL TES ZIL NO
axaminar? 1 ☐ Yas 2 ☐ No	Hospital: 1 Anpatient 2	☐ ER/Outpatient 3☐ DC	Other:	Homa 5 ☐ Rasidance 6 ☐ Ott	nar (Specify)
• 27 Manner of Deeth	28e. Data of Injury (Month, Day Year)	28b. Tima of Injury M	28c. Injury at Work? 1 ☐ Yas 2 ☐ No	28d. Dascribe how Injury occur NA	red
1 Natural 5 Panding Invastigation 3 Suicida 4 Homicide Certifying Phone) 29e. Certifiar (Check only one) 29h Signatura and tilbural certifier		noma, farm, straat, factory	d naturaly	281. Location (Streat and Number City or Town, Stata)	
29e. Certifiar (Check only one) 29e. Certifying Ph (Check only one)	ysician: To the best of my kniner: On the basis of axaminand mannar stated.	owledga, daath occurred atlon and/or investigetion	et the time, dete and place, In my opinion, daath occ	ce, and dua to tha causa(s) and mo curred at the time, deta end plece,	annar as steted. end dua to tha causa(s)
29b. Signatura and title of certifiar	AZIMD	290	D 4 4 1 1	64 2/13	d (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth **Physician** Month Laura Marie Thompson February /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Sacurity Number If Under 1 Yaar | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) Oct 27 / 7. Aga (In yrs. last birthday) Birthpleca (Stete or Foreign Country) **Funeral** 1 □ M 2 🕟 F Deys Hours 164-28-7454 62 Yrs. Director 1935 Butler. Usual Residence of Decedent 10e. Stete 10b County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Modical Exameter must be nothed at 10d. Inside City Limits Director Frederick 1 ☐ Yes 2 ☐ No Knoxville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Peges 1 and 2 should be filed within 72 hours efter death with next of Health and Mentel Hygione.

Inter if item 27 is marked other than "natural", or items 23s or usy or other traumatic event, Its Mod at Exercises man 19024 Miller Avenue 21758 12. Wes Dacadant Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced Completed Rosebud Ent. Fred. 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Cent. Nursing Assistant Laura & Dicks Pizza 10 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Norman W. Spohn Laura A. Johnston 19e. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) W. C. Thompson, Husband 19024 Miller Avenue Knoxville MD 21758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State *Burial 2 Cremation 3 Removel from State permit. Pege Depertment of Important: If any Injury or St. Many's Cemetery 2/19/98 Knoxville, MD 21. Signeture of Funeral Service Licenses

Williams, 4 Donetion 5 Other (Specify) 22. Neme end Addrass of Facility

John T. Williams Funeral Home

100 Petersville Rd Brunswick, Owner MD 21716 23a. Part1. Enter the disease, or complications that caused tha daeth. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or hear failure. List only one causa on aech line. Approximate Interval Between Onset end Death **Physician** /Medical Immediete Ceusa (Final Preamonia disease or condition rasulting in death) Examiner Due to (or es e consequence of) Examiner lician and buriel-transit Cancer Hospital or Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Diseese or Injury that initiated events rasulting in death) Lest Due to (or as e consequence of): P.O. Box 68760. Completed by Physician/Medical the Dua to (or es e consequance of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Records, 24b. Wera eutopsy findings aveileble prior to complation of causa of deeth? 24a. Was en eutopsy performed? this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital funeral director. 25. Was casa referred to medical examiner? 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Certification: To 1 Yes 2 Ne 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA 28a. Deta of Injury (Month, Dey Year) 27. Mannar of Deeth 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of After 1 Naturel
2 Accident 5 Panding after death.

Director: Aft 1 Yas 2 No investigetion 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Straet end Number or Rural Route Number, City or Town, Stete) filled in by 4 - Homicide • Funeral 29a. Certifier 🔟 Certifying Physician: To tha best of my knowledge, death occurred et the tima, date and piece, and due to the ceuse(s) and menner es stated. Medical within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end mennar stated. 幹 29b. Signature and tale of certifier 29d. Data signed (Month, Dey, Yeer) 29c. Licanse number 22161 ed ceuse of daeth (Itam 23a) (Typa, Print) NU Frederick Ind 2170L

State Registrar

31. Date filed (Month, Day, Yaar)

32. Registrer's Signetura

the second of the second

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death 3. Time of Death Garlem Month 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Branzywine Bacen Westwood | If Under 1 Yaar | If Under 24 Hrs. | S. Date of Birth | Months | Deys | Hours | Min. | Months | Dey Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year | Year 7. Age (In yrs. lest birthday) Yrs. 10 M 20 K Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 9170 1₽Yes 2□No 10e. Street end Number 14701 Baden Westur 10f. Zip Code 10g. Citizen of Whet Country? 20613 454 11 Marital Status 12. Was Decadant Ever in U.S. Was Decadent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Bleck, White, atc. Armed Forces? 1 Yas 2 No If Yes, Give Yaar or Detes: 1 Navar Married 25 Married Specify: Uh, Te 1 Yas ZETNo Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest greda completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) House wife 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme)

death with the Maryland or items 23a or 28a-f show event, the Medical Examiner must be notified at Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene. Maryland 21215-0020 "natural", al Hygiene. is merked o other traumatic Department of Health as Important: if item 27 is any injury or other traugence. Baltimore,

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

2

Funeral

Director

Physician /Medicai Examiner

Examiner Physician/Medical þ Be Completed 2

or Attending Physician: The lew requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760.

Samuel Alexander Mull Tinia 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Ihomas Von Garken - Son 20b. Place of Disposition (Name of cametery, cremetory or other place)

Trinity Episcopal Church 1998

Cem. 20e. Method of Disposition Feb. 24, 20c. Location - City or Town, State Buriel 2 Cremetlon 3 Removel from Stete Upper Marlboro, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735 3a. Part Leafer the disease, or complications that causad the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heer feilure. List only one ceuse on each line. Approximeta Intervel Betw Onsat end Death Immediate Ceuse (Fine) disease or condition resulting in deeth) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Dua to (or es e consequença of) Pert II. Other significant conditions contributing to death but not resulting In the underlying cause given in Pert f. 23b. Did tobacco use contributa to the causa of death? 1 Yes 25 No 3 Probably 4 Unknown 24b. Were eutopsy findings avelleble prior to completion of cause of death? 24a. Wes en eutopsy performed? N/A 1 Yes 28 No 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 52 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred-28c. Injury et Work? 5 Pending Invastigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not ba 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Exertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner steted. (Check only one) Signature end title of certifiar 29c. License number 100 2 2 5 9 29b. Signature end title of certifiar 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

(ene Grace MD 4131 Piscataway Rd, Clinton, MD)

the ettending physician certificate After this Certification: To the Hospital or Attending within 24 hours efter death.

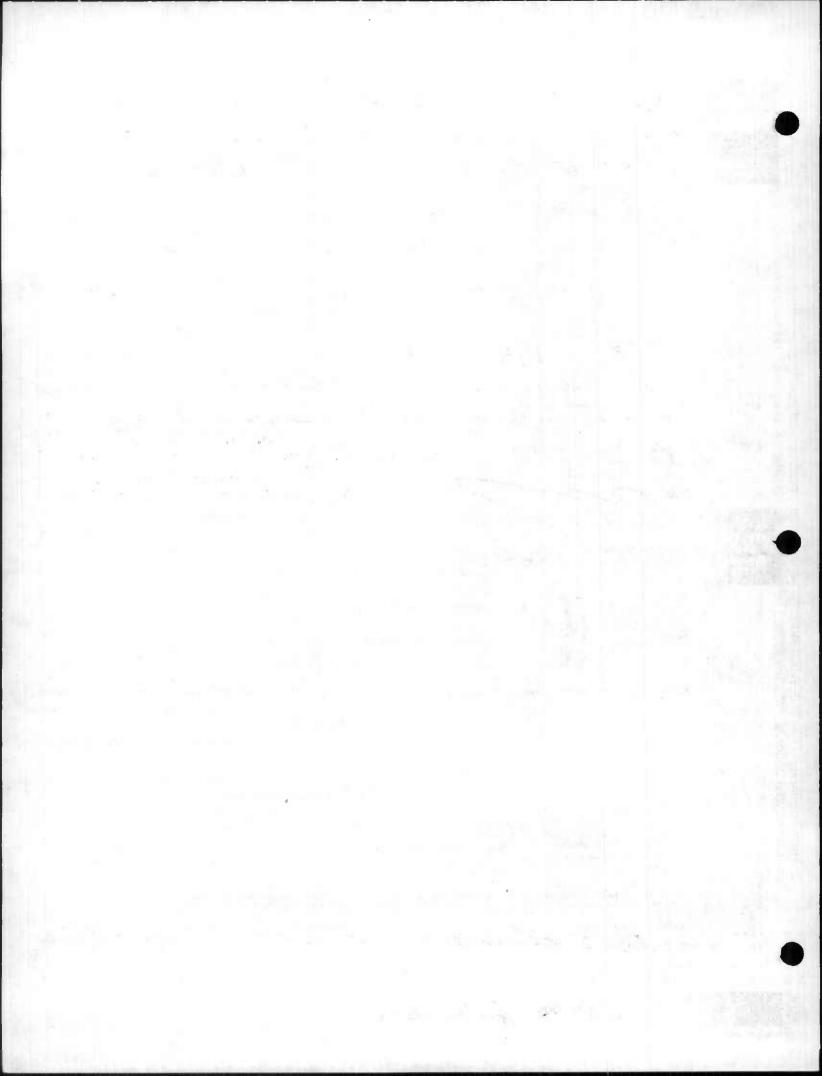
To the Funeral Director: Afte completely filled in by the fune Medical

State Registrar

31. Data filed (Month, Dey, Year)

FEB25

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Physician Voo Month Phyllis Angeline Whiteman 1998 4:30 a.m. February, 23, /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Egle Nursing Home **Allegany** Lonaconing 5. Sociel Security Number if Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) **Funeral** Birthpiece (State or Foreign Country) 1□M 20 F Deys Hours Yrs. 67 Director 217-28-0644 November 9, 1930 MD Usuei Residence of Decedent death with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner naut be notified at Director Allegany 1 ☐ Yes 2 ☑ No Lonaconing 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 6 21539 15319 Old Beechwood Road S.W. USA Items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours aftar 1 Never Married 2 Married Baltimore, Maryland 21215-0020 White "natural", or 1 Yes 2 No Specify: Completed by 3 N Widowed 4 Divorced 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th and Mental Hygiena.

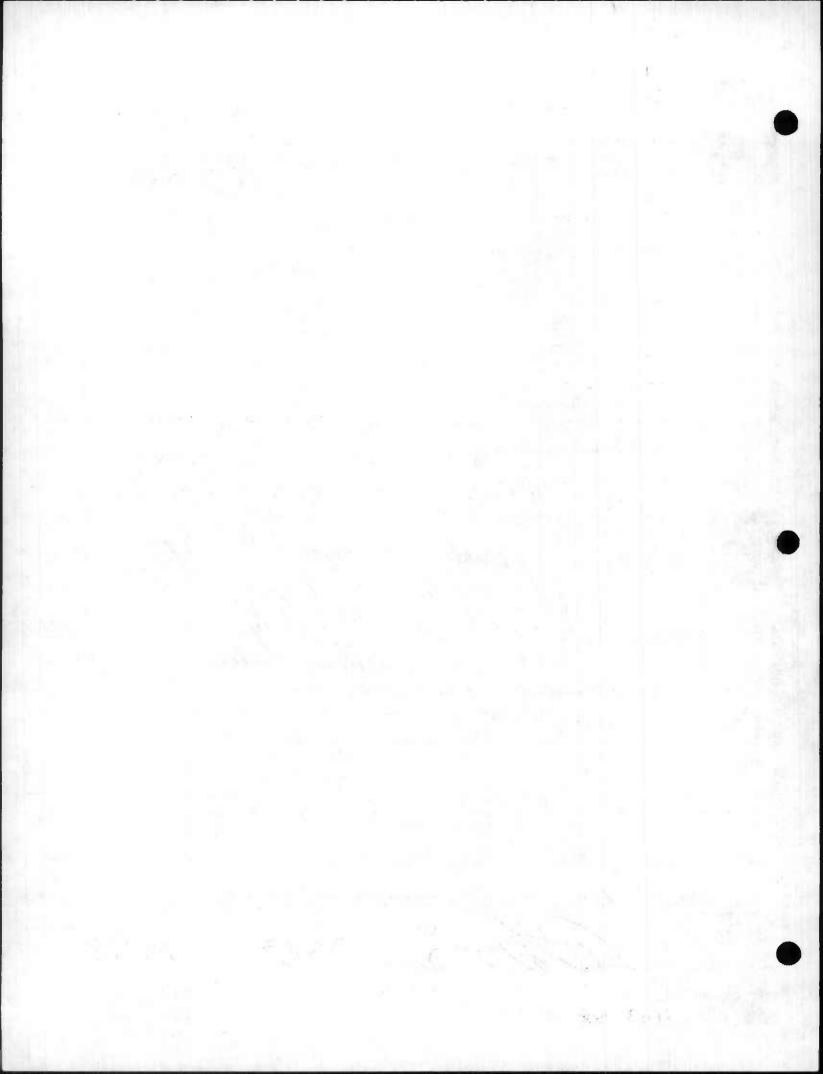
7 is merked other than traumatic event, the Me Elementery/Secondery (0-12) College (1-4or 5+) Beautician Hairdressing 17. Fether's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other sny injury or other traumatic event page. 18. Mother's Neme (First, Middle, Malden Sumeme) Be Lawrence E. McKenzie Katherine Nolan 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 48383 Rose Ann Chaney-Shea Niece 5300 Chateau Thierry Blvd. White Lake, Michigan 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 26, Lonaconing, MD Feb. 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) Green Cemetery 1998 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility nenz Eichhorn-McKenzie Funeral Home P.A. 23a. Pert1/Enter the disease, or compilections that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.

Approximate Intervel Between Onset end Deeth Physician /Medicai Immediate Cause (Finel diseese or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificeta be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest for use as the buriel-tran Division of Vital Records, P.O. Box 68760. es e consequence of) erai Urrector: After this certificate has been signed by the e filled in by the funeral director, page 2 should be detached t Pert II. Other significant conditions contributing to death but not mention in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ Medical Certification: To Be Completed 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 2D No 1 🗌 Yes or Attending Physician: 25. Wes cese referred to medicei examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 | Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ER/Outpetient 3 DOA After this 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et. Work? 28d. Describe how injury occurred 1 Neturei 2 Accident 5 Pending Investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 3 Suicide 6 Could not be 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 29a, Certifier 12 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner es stated.
2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 10 30. Name and address of of death (Item mis 32. Registrer's Signeture 31. Dete filed (Month, Dev. Yeer) State

Registrar

7



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death **Physiclan** Feb. 24, 1998

4b. City, Town, or Location of Death 4c. County of Death Leo Wilson /Medical 10:30 am 4a. Facility Name (If not institution, give straat and number) Examiner Frostburg Village Nursing Home Frostburg Allegany 5. Social Security Number 6. Sex XXM 2□ F If Under 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foraign Country) **Funeral** Months Days Hours Yrs. Director 217-10-6967 86 Jul.9, 1911 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 28a-f show 10d. Insida City Limits ir than "naturel", or items 23a or 28a-f show No Yes 2 No Director Cumberland Maryland Allegany 10e. Straet and Numbar 10f. Zip Coda 10g. Citizen of What Country? filed within 72 hours after deeth with 1725 Bedford St. 21502 USA Funerai 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: SpecifWhite þ 3 ☐ Widowad 4 ☐ Divorcad Completed 15. Dacedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Owner/Operator 12 Construction Pages 1 and 2 should be filed went of Health end Mental Hygie ant: If Item 27 is marked other t 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Bertha S. (Schaeffer) 0 Bruce Wilson 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Honeysuckle Lane Frostburg MD. 21532

20b. Place of Disposition (Name of camefery, crematory or other place)

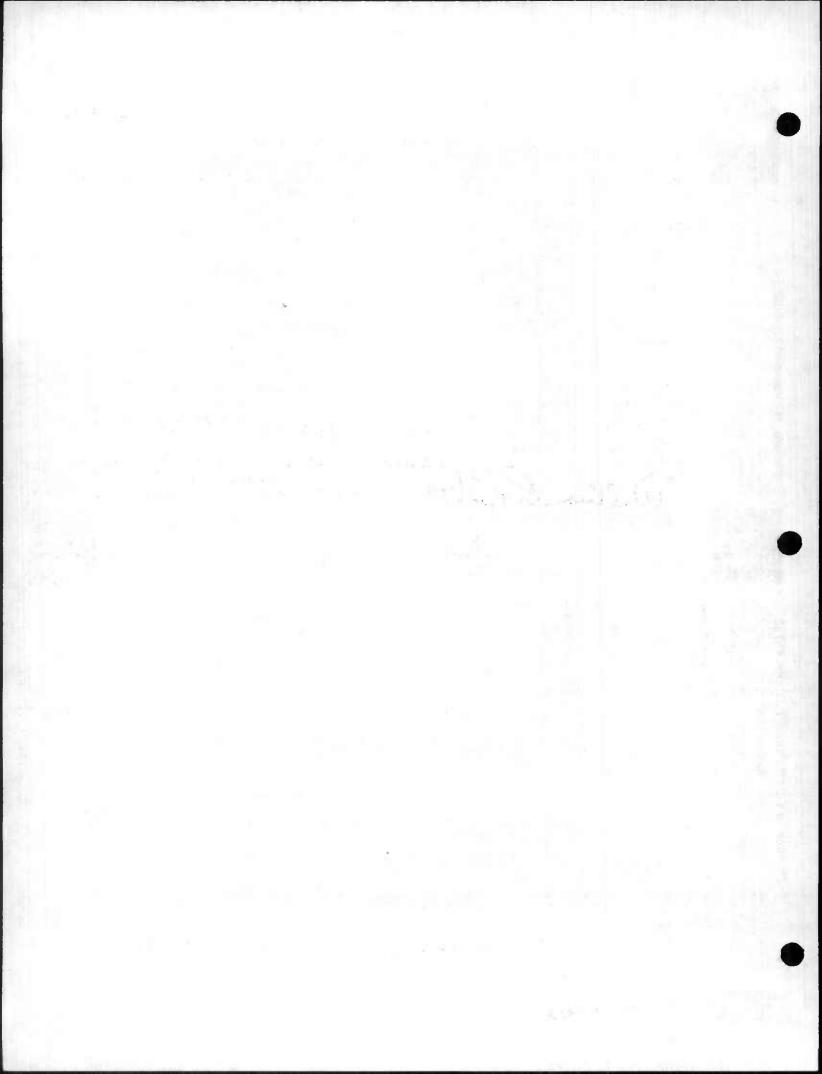
Date 20c. Location - City or Town, State permit. Pages 1 and 2: Department of Health et important: if item 27 is eny injury or other traugnts. Mary B. Wilson 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial P.2/28 Cumberland, MD 21. Signature of Funeral Service Licanses 22. Name and Address of Facility Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502 23a. Part1. Enter tha disaase, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each in the cause of th ntarval Between Onsat and Death **Physiclan** /Medical heart Foilure Immediata Cause (Final ongestive 2 years disease or condition resulting in deeth) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ettending physician and for use es the buriel-trar Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributs to the cause of death? mit Chronic as pinatini 1 Yes 2 No 3 Probably 4 Unknown ð certificate hes been si irector, page 2 should 24b. Were autopsy findings available prior to Completed 3 yudrome. Chronic atrial fibrillation 24a. Was an autopsy performed? completion of causa of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred After 1 5 Pending investigation spital or Attending nours after death. neral Director: Afti 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medicai completely (Check only 29b. Signature and title of cartifier 29c. Licansa number 29d. Data signed (Month, Day, Year) Jourdhir MA Feb 26. 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 744 S. L. Sandhir, M.D., 48 Tarn Terrace, Frostburg, Maryland 21532

Registrar

State

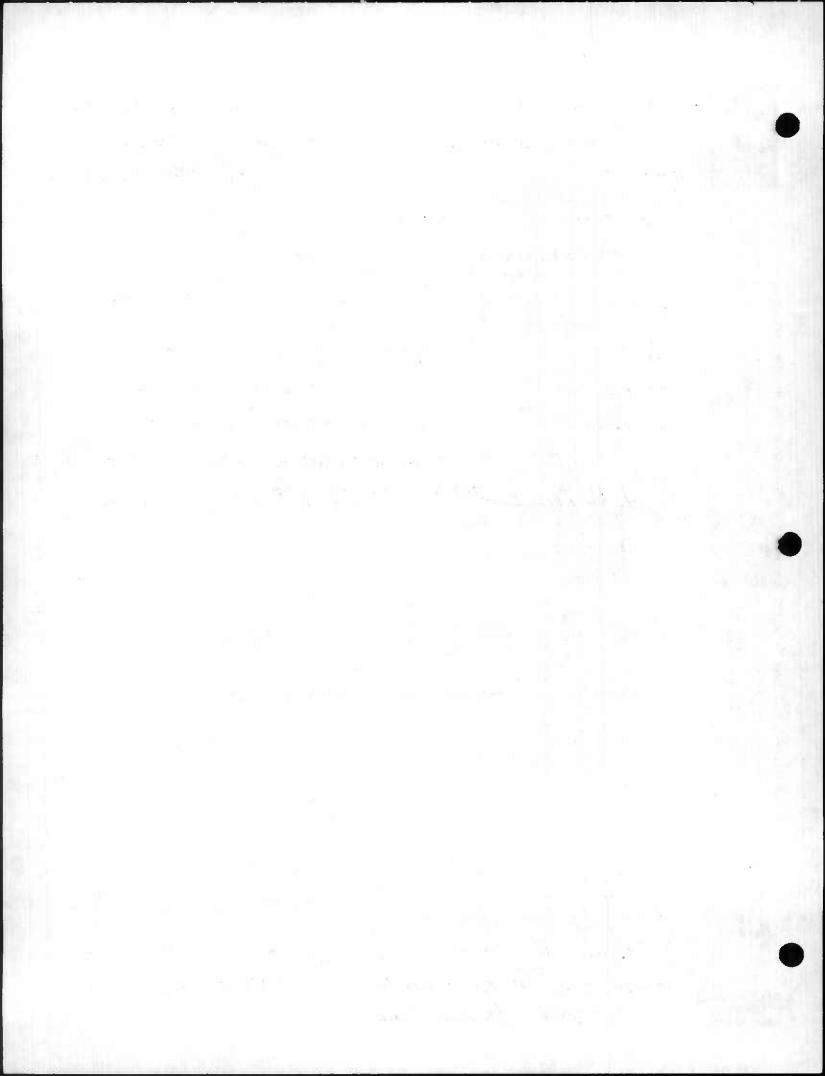
31. Date filed (Month, Day, Year) FEB 2 7 1998

32. Registrar's Signature able divideor flender



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ian	Н	VERA FRANCES	•					Februa			:45 AM
ical iner	4	a. Fecility Neme (If not institution,		nber)			4b. City, Town, or				
	н	Physicians Me	emorial H	lospita	1		La Plata	a	CHARI	LES	
	1	175-20-1196	6. Sex 1 □ M 2 □ X F	7. Age (In yrs 71	s. last birthdey) Yrs.	If Under 1 Year Months Deys			th 1926	9. Birthplece Country) Pennsy	(Stete or Fore
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0	N	Maryland Charles	3		Waldorf	ation					nside City Lim □ Yes 2001
Directo	1	0e. Street end Number				10f. Zip Code			10g. Citizen of V		
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ed ed		15. Decedent's	Education completed	lucation 16e.		ent's Usuei Occu	pation	dina	16b. Kind of Bu	usiness/Industr	у
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		9e. Informent's Neme/Reletionshi	p (Type, Print)				end Number or R				(e)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **EDWARD** WALDEN 1998 RICHARD FEB 20 1:30 am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 23000 OLD HUNDRED RD MONTGOMERY DICKERSON If Under 1 Yaar | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) Months MOM 20 F Yrs. 82 GA 423-05-4529 Usual Rasidence of Decedent 10c. City, Town or Location 10d. Inside City Limits Montgomery Dickerson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23000 Old Hundred Road 20842 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 ☐ Yas 2 ☑ No If Yas, Give 1 Naver Married 2 XMarried white 1 ☐ Yes 2X No π Yas, Gíve Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Dept. of Agriculture Federal Government 1.7. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame)

Patricia W Smith daughter 15714 Ancient Oak Dr. Gaithersburg, ME

22. Name and Address of Facility

Hilton Funeral Home

20b. Place of Disposition (Name of camatery, crematory or other place)

Monocacy

permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylan Department of Heelth and Mentel Hygiena. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-4 show any injury or other treumsite event, the Medical Examinat must be notified at Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

10a. Stata

MD

Director

Funeral

þ

Completed

2

Robert E. Walden

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

19a. Informant's Name/Relationship (Type, Print)

1 Burlai 2 □ Cramation 3 □ Removal from Stata

Funeral

Director

with the Meryland

Physician /Medical Examiner

Box 68760.

P.O.

Division of Vital Records,

Examiner lician end buriel-transit physician the buriel Physician/Medical use as t Po eu þ Completed peen hes pege 2 certificate this funeral Certification:

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. ANDOMINAL ANTURY SW consequence of): ANTERIOSCIANOSIS consequence of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of of): Consequence of): Consequence of of): Consequence of): Conseq Immediate Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pul ways my 1 Yes

OBSTRUCTIVE UND PATH'S

23b. Did tobacco usa contribute to the cause of death?

Beallsville, MD

ZX No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Ware eutopsy findings available prior to completion of cause of death?

AB878

Approximata Interval Between Onsat and Death

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case reterred to medical 1 Yas 2 No 27. Manner of Death Natural

5 Pending invastigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

26b. Tima of

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Homa 28c. Injury st Work? 1 ☐ Yes 2 ☐ No

Maud Nunn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2/23

oma 5 Fesidanca 6 Other (Specify)
28d. Describe how injury occurred

28f. Location (Streat and Number or Rural Route Number, City or Town, State)

ROND: Podkaville MD 2083)

29a. Certifier (Check only

2 Accident

3 ☐ Suicide

4 Homlcide

fix Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

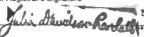
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Type, Print) (Type, Print) (Type, Print) MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature



State Registrar

Medical

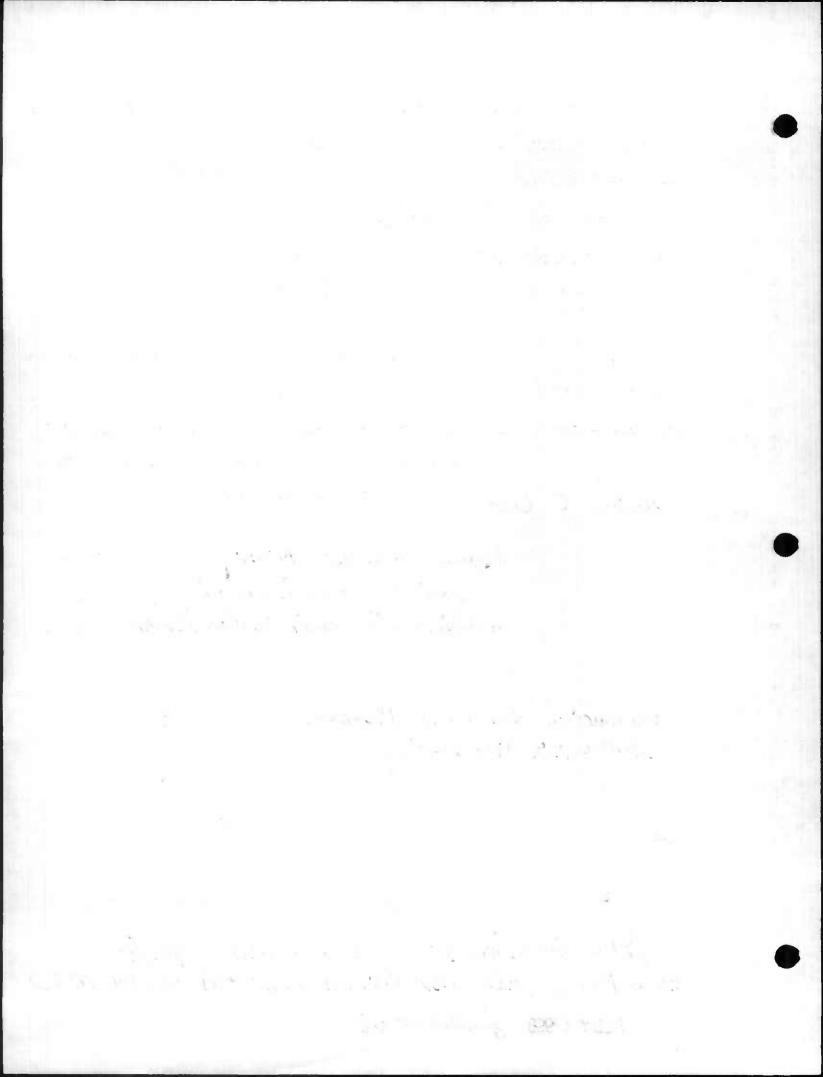
DHMH 16 Rev 6/95

Director: After

To the Hospital or Attending within 24 hours effer death.

To the Funeral Director: After completely filled in by the function.

Attending



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Many Agnes Jenkins Walken 12 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Health Care Center Frederick Frederick 5. Sociel Sacurity Number If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 6. Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Sept 7 / Birthplece (State or Foreign Country) 1□M 21XF 217-32-6144 Usuel Residence of Decedent 76 Yrs Brunswick MD 1921 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits MD Frederick Brunswick 1 X Yes 2 □ No 10e. Straet and Number 10g. Citizen of Whet Country? 10f. Zip Code USA 308 Brunswick Street 21716 12. Wes Decadant Ever in U,S. Armed Forcas? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, atc. 1 ☐ Yes 2X No If Yes, Give Year or Detes: 1 ☐ Nevar Married 2 ☐ Married White 1 ☐ Yas 2 ☐ No 3℃Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Calteria Worker Brunswick Elementary 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) James William Jenkins Clara Agnes Crowl 19e. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Straet and Number or Rurel Route Number, City or Town, Stete, Zip Code) Judith A. Florance (Daugh) 1393 N. Van Dorn St Alexandria VA 22304 20a. Method of Disposition **ONBurial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) St. Many's Cemetery 2/16 Petersville MD 21. Signifure of Fundrei Service Liceposte William 32 Name and Addrass of Facility John 1. Williams Funeral Home Banbana A. Williams, Owner 100 Petensville Rd Brunswick MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximete intervel Batween Onsat end Deeth PREUMONIA immediate Cause (Final disease or condition resulting In death) WK Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting In deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? HEART FALURE 1 Yes 2 No 3 Probably 4 Unknown CNGETTVE 24e. Wes en eutopsy performed? 24b. Wera eutopsy findings available prior to completion of cause of deeth? FRRILMON 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes casa referred to medical exeminer? 1 ☐ Yes 2 No 26. Place of Deeth (Check only one) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred

Physician /Medical Examiner

permit. Page Department of Important: If any injury or once.

Physician

/Medical

Examiner

Director

Funerai

Completed by

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Manylan neat of Health and Mental Hygiene. In thit if term 2 is marked other than "netural", or items 23a or 28a-f show any or other traumetic event, the Masses Travier man to notified as

Baltimore, Maryland 21215-0020

for use as s certificata has been signed by the a director, page 2 should be detached to this certificata

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Records,

of Vital

Division

Physician/Medical Examiner by Be Completed Certification: To filled in by the funeral After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

27. Menner of Deeth 1 Naturel

5 Pending investigation 2 Accident 3 Suicide 4 ☐ Homicide

6 Could not be determined

28e. Dete of Injury (Month, Dey Year)

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Yes 2 No

My

Location (Street end Number or Rurel Route Number, City or Town, State)

(Check only one) 29b. Signature and tiple of certifier

29e. Certifier

Medical

State Registrar

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mennar stated. 29c. Licensa number 40

29d. Date signed (Month, Dey, Year)

30. Neme end eddress of person with J KYNE 31. Dete filed (Month, Dey, Yeer)

completed cause of deeth (Item 23a) (Type, Print)

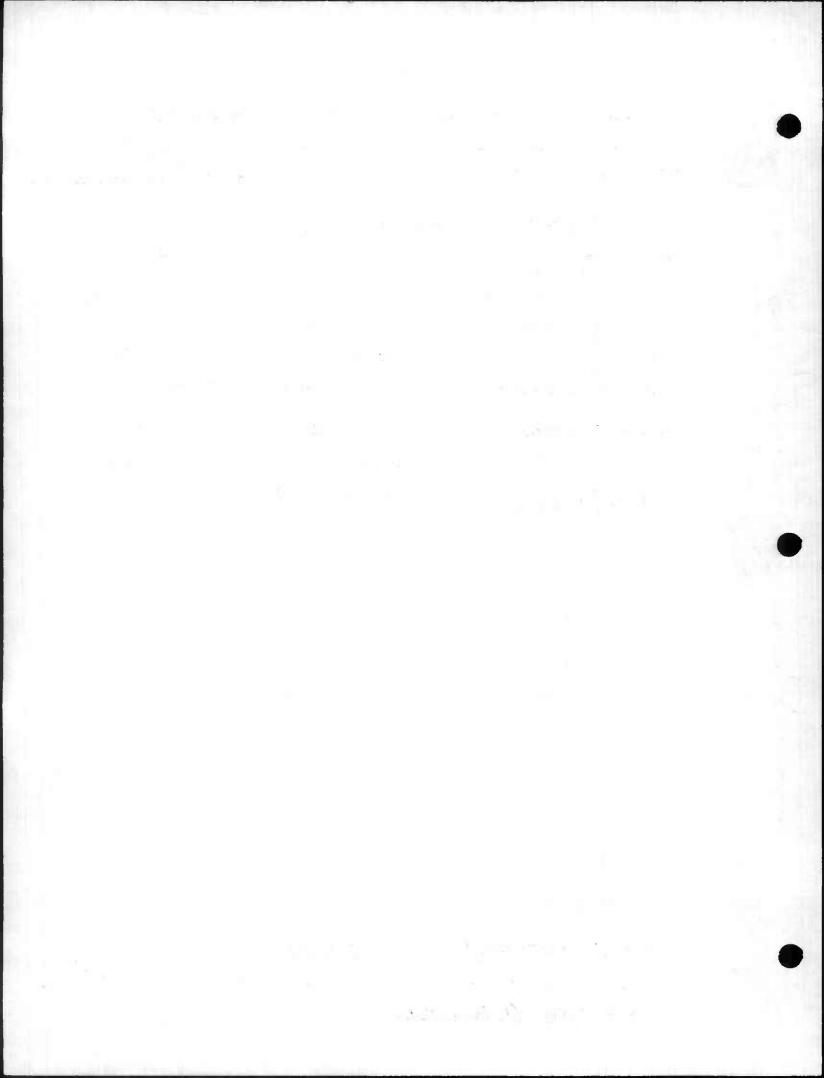
Jan



To grand entering the o

State of Maryland / Department of Health and Mental Hygiene

	-	Decedant's Nama (First, Middla, Last)		Cert	ificate of	Death	2. Data of Dea	eg. No.	0	3. Time of Death
Physici						17	Or 1	Month	Day	Yaar	
_/Medie		4a. Facility Nama (If not institution, giva		NELL		Y	Ab City Town or	Februar Location of Death			2:50 AM
Examir	ner	WATERVIEW HEAL					SALISE		WICON		
Francis		5. Social Sacurity Number 6. Sa		aNIER ga (In yrs. las	t birthday)	If Undar 1 Yaa					ana /State or Forei
Funeral Director			TM WITE	6	Yrs.	Months Days	Hours Min.	8. Data of Birth (Month, Day			iace (Stata or Foreig try) Carolina
and and		10a. Stata 10b. County		10c. City, T	own or Loca	ation				10	0d. Insida City Limit
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		11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Armed Forcas? 1 Yas 2 If Yas, Give Yaar or Datas:	7		as Decedant of Yas, specify Cul	Hispanic Origin? (S ban, Maxican, Puar Specify:	Specify Yas or No- to Rican, atc.)		, Whita,	
ithin 72 hc	Completed	15. Dacadant's Edu (Specify only highast grad Elamantery/Secondary (0-12)	cation a completed) Collaga (1-4or	5+)			pation a during most of wo ed)	rking	16b. Kind of Bus		lustry
filed within Hygiene. ther than ent, the Me	S	12	1		Hou	sewife			Domes		
d off	Be	17. Fathar's Nama (First, Middla, Last)						ma (First, Middla, I		a)	
should be nd Mental marked o umatic eve	ို	William Thomas P					Jessie	Julia Wa	rren		
le m ie m		19a. Informant's Name/Raietionship (Ty	pe, Print)		19b. Mailing	Addrass (Stree	t and Number or R	u <i>ral Rou</i> ta Num <i>bei</i>	, City or Town, S	Stata, Zip	Code)
permit. Pages 1 and 2 should be filed within 72 hours after dee Operational of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel; or items any injury or other traumatic event, the Medical Example and Dice. To Be Completed by Funer		Dr. Raymond M. Yo 20a. Mathod of Disposition 1⊋ Burial 2 □ Cramation 3 □ F		20b. Plac	9630 a of Disposi atary, crema	Club S. tion (Nama of ntory or other pla		Data	Sarasota 20c. Location - (
		4 Donation 5 □Othar (Specify)			sons (Cemetery	7	2/28/98	Salisbu	ry,	MD
permit. Departri Importa any inji		21. Signature of Funarai Sarvice Licens	E.	~ 0	LTO.	Nama and Addr	Funoral L	10me			
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/Medical Examiner		immediata Causa (Finai disaasa or condition resulting In death)	MEto	ISTA	71%	110	IER C	9NCEX	3 ,	2	5 mon
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cien burie	<u>a</u>	Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated avents									
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To the Hospital or Attending Physicien: within 24 hours efter death To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicida 6 Could not be datermined 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)							reet and Numbe o, Stata)	r or Rura	Routa Number,
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Amended # 236, MdS, Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

3/3/98, Allegany County State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Data of Death

Physician FEBRUARY 21 1998 William Edward Zapf Sr. /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, give street and number) 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Funerai Days MOM 20 F Yrs 72 Director 220-16-6128 Usual Rasidance of Dacadent with the Maryland 10a Stata 10b. County 10c. City, Town or Location ral', or Items 23a or 28a-f show Examiner must be notified at Cumberland Director Allegany 10e. Straat and Numbar 10f. Zip Coda 10g. Citizan of What Country? 616 Fairview Avenue 21502 USA death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ther any injury or other traumatic event, the Medical Examples. 1X Yas 2 □ No If Yas, Giva Yaar or Datas: WWII 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas X No Specify: p Specify. 3€ Widowad 4 Divorced Completed 15. Decedant's Education (Specify only highast grada complated) Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CSX Transportation Co Retired Supervisor 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Surnema) Be George Zapf Agnes (Hodel) 2 19a. Informent's Nama/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) 616 Fairview Avenue Cumberland MD 21502 Alan P. Zapf-son 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State St. Patrick's Cemetery Cumberland MD 4 ☐ Donation 5 ☐ Other (Spacify) 02/24 22. Nama and Address of Facility
Scarpelli Funeral Home, P.A. 21. Signature of Funaral Sarvice License Cumberland MD 21502 23a. Part / Entar tha disaasa, or complications that mailed the shock, or heart feilura. List only one cause on some line. death. Do not antar the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medicai Immadiata Cause (Final disaasa or condition resulting in deeth) ADENOCARCINOMA OF THE COLON WITH METASTASIS TO THE Examiner Dua to (or es e consequence of): Examiner LIVER sician end burial-transit be executed Sequentially list conditions, if any, laading to Immadiata causa. Entar Underlying Ceusa (Disaasa or injury that initiated avants rasulting In daath) Last Dua to (or as a consequence of): Box 68760. ettending physician for use as the buria Physician/Medical Dua to (or as a consequence of):

3 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 17 You 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings aveilable prior to complation of causa of death? 24e. Wes an eutopsy performed? 1 ☐ Yas 2 ₺No 1 ☐ Yes 2 No 25. Wes casa rafarrad to medical 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 Yas 2 No 1 M Inpatiant 2 ER/Outpatiant 3 DOA 28c. Injury at Work? 27, Mannar of Death 28a. Deta of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 5 Panding 1 Naturai 1 Yes 2 No invastigation 2 Accident 6 Could not ba dataminad 3 Suicida 28a. Placa of Injury - At homa, farm, straet, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

4 Homicida

🗺 Certifying Physician: To the bast of my knowledge, deeth occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as statad.

(Check only one) 29b. Signature and title of certifiar

31. Data filad (Month, Day, Year)

FEB \$ 4 1998

2 Medical Examiner: On the besis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

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FEB. 22, 1998

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Approximate Interval Batw Onset and Daath

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30. Nama and addrass of person who completed cause of oeeth (Itam 23a) (Typa, Print)

ROBUSTIANO BARRERA M.D., 500 MEMORIAL AVE., CUMBERLAND, MD 21502

State Registrar

signed by the e

page 2 hes

certificate

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After

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To the Hospital within 24 hours or To the Funeral Completely filled

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Certification:

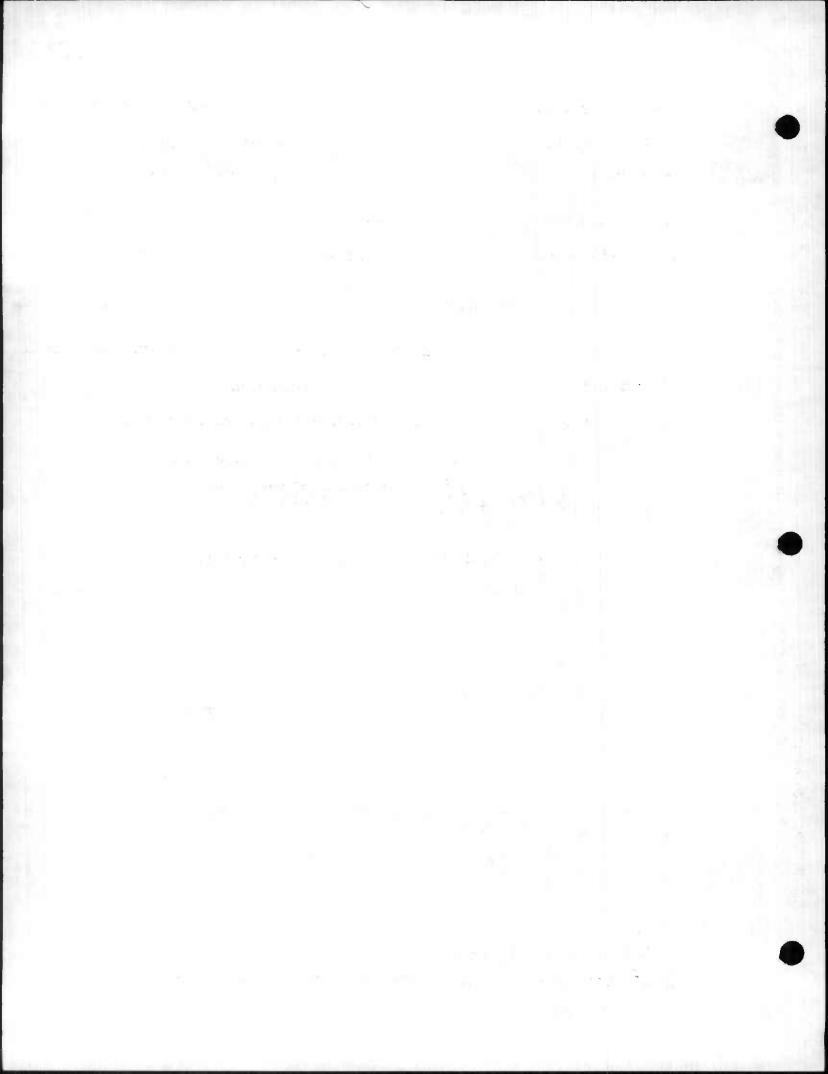
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29a. Cartifiar

Division of Vital Records, P.O.

WILLIAM ZAPF 220-16-6128

32 Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Daath 3. Tima of Death Month **Physician** March 06, 1998

4b. City, Town, or Location of Death 4c. County of Death Richard Benton Ahrens, Sr. ' /Medical 3:15 AM 4a Facility Name (If not Institution, give street end number) **Examiner** Holly Hill Manor

5. Social Security Number Towson if Under 24 Hrs. Hours Min. Baltimore Co. If Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** Days 1 M 2□ F Vrs Director 212-20-0619 73 April 09,1924 Baltimore, Md. Usual Residence of Decedant with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yas 2 No Director Maryland Baltimore Co. Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2103 Eastham Road 21093-3307 Funeral United States 12. Was Decedant Ever in U,S. Armed Forces? Navy 12 Yes 2 □ No Navy If Yes, Give Year or DatasW.W.II 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after n and Mental Hygiene. Is marked other than "naturel; or ite 1 Never Married 2 Married altimore, Maryland 21215-0020 1□ Yes 2√2 No Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry I Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 08 Collections Banking other traumatic avent. 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Melden Sumeme) William Christopher Ahrens 2 Lucy Emma Courtice 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Coda) permit. Peges 1 and 2 sh Department of Health and Important: If itsm 27 is m any injury or other traum page. 6205 Birchwood Ave. Baltimore, Maryland 21214-1102 Mr. Richard Benton Ahrens, Jr. 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Dulaney Valley Mem. Gard. 3/09/98 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Lican pe Jeffrey L. Gair 1050 York Rd. Towson, Md. 21204 Phrt. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disaase or condition rasulting in daath) 4 days a. Infracerebral New Due to (or as a consequence of): nemorrhage Examiner Examiner Cerebrovasculas ician and burial-trans Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disaasa or Injury that initiated events resulting in death) Last certificate be exec Box 68760 physician Physician/Medicai the Due to (or as a consequence of) 98 use a for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. deteched signed by the detects 1 Yes 2 No 3 Probably MyUnknown à 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed Deen completion of cause of death? page 2 hes certificate director. 25. Was casa referred to medical axaminer? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) To 1 Yes 20 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? After t Certification: Attending Natural 5 Pending or Attending effer deeth. 2 Accident Investigation 1 Yes 2 No 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 4 I Homicida Mospital 24 hours e Funeral C edical 29a. Certifian Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to tha causa(s) and mannar as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceusa(s) and manner stated. To the To the To the 29b. Signature and title of contilen 29d. Date signad (Month, Day, Year) 29c. License number 6 MARCH 1998 17041 lu

Registrar

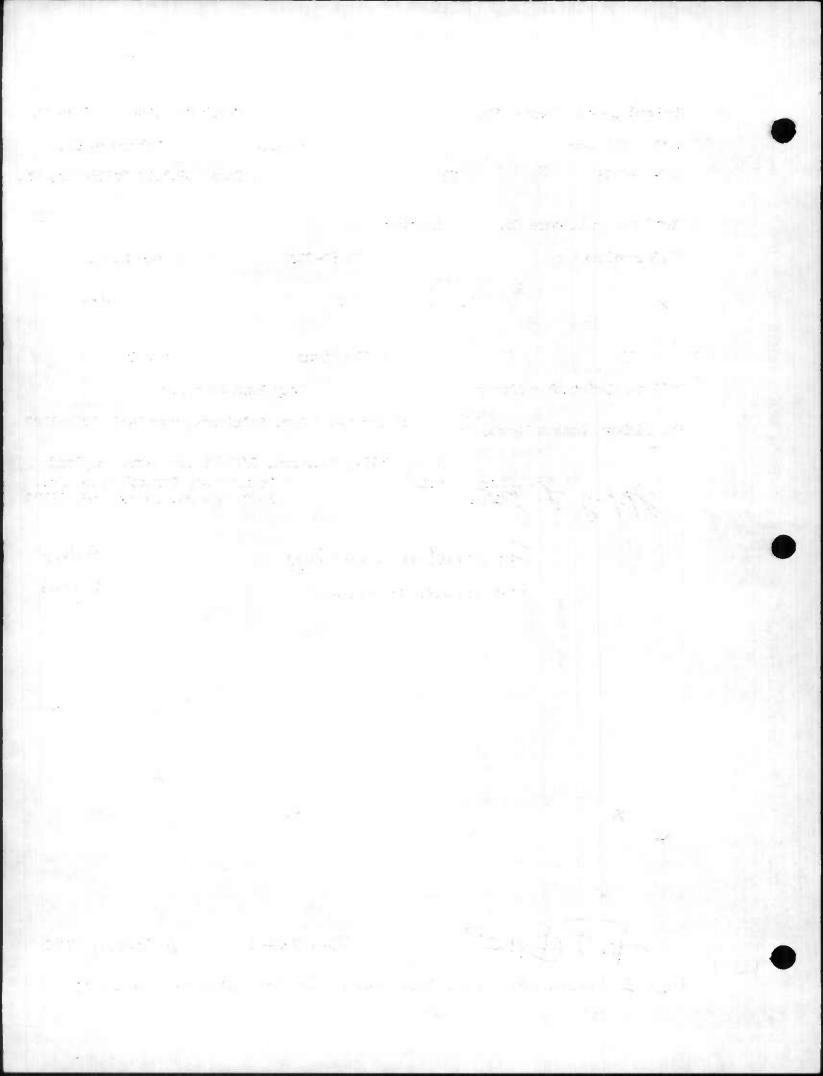
Leavey 31. Data filed (Month, Day, Year) MAR 0 9 1998

York 1205 Julia Daydon-Randall

Road

St 38 Litharville MD 21093

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Biack Indelibie ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) NMN Arms June **Physician** 11:47 AM March 3, 1998 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Baltimore Rossville Franklin Square Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys 1□M 2월F 83 Yrs. 2,1914 236-26-8760 Nov. Kentucky Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Dundalk 1 Yes 2 No Baltimore Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 7268 Bridgewood Drive United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indien, Black, White, etc. 11. Marital Status I ☐ Yes 2 ☐XNo If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify. P 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Years Housewife Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Cora Lee Biaton John Wesley Brown 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1226 Bonaire Road Forest Hill, MD 21050 Mr. Brownell Arms/Son 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 3/6/1998 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signeture of Funeral Service Licensee L. Gebes Johnny Dundalk, Maryland 7922 Wise Ave. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 20 No 1 ☐ Yas 3 Probably 4 Unknown à 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 Yes 2 1 Inpatient ER/Outpetient 3 DOA 27. Manper of Beath 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Medical Examiner: On the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

21224

Division of Vital Records, ò Hospital å **Funeral**

Director

r than "natural", or hama 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or han any injury or other traumatic event, the Medical Exertine once.

Physician /Medical

Examiner

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certificate

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Affer

after deat Director:

24 hours Funeral

Within 2

uneral

Medical

29a. Certifier (Check only one)

2

altimore, Maryland 21215-0020

with the Maryland

death

Paul Valle, MD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAR 0 9 1998

30. Name and address of person who completed cause of eath (Item 23a) (Type, Print)

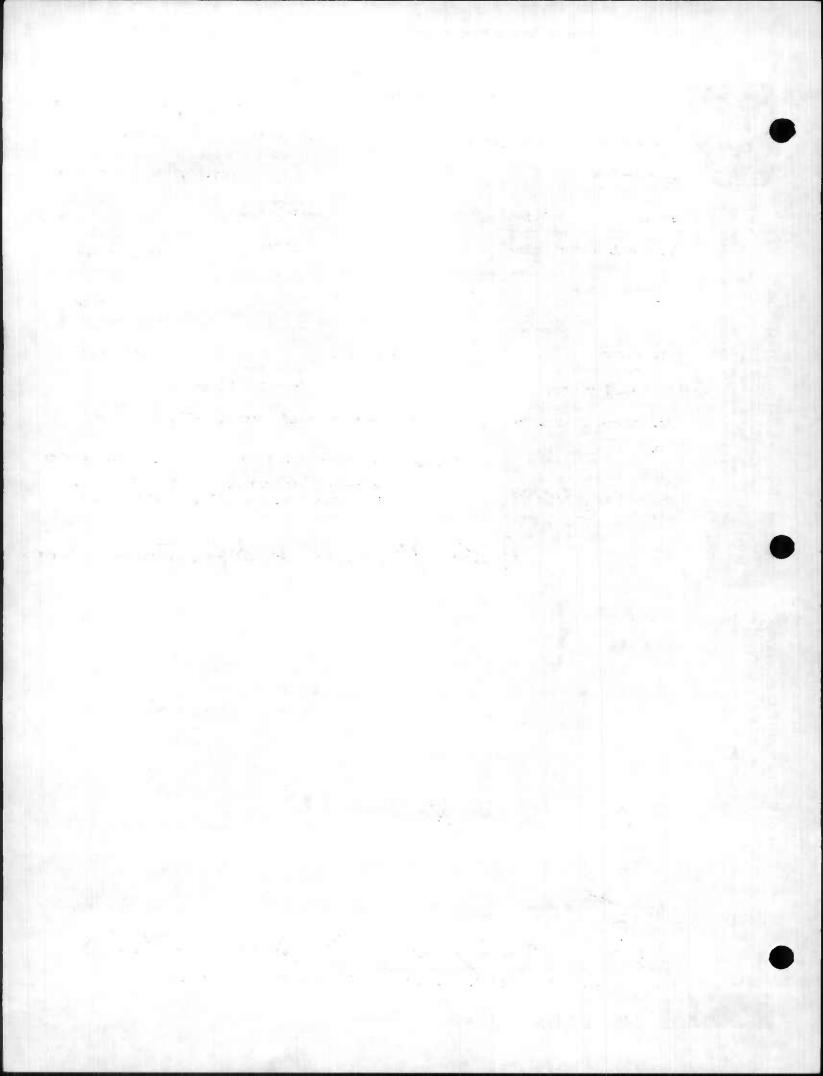
32. Registrar's Signature

who Davidson-Randall

no

1012 Old N. Pt. Road Baltimore, Maryland

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene R Certificate of Death per FH G757 3/17/98 EW 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month rown 110 March 08, 1998 LOUIS DM /Medical 4a. Fecility Name (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing Hore Howard

9. Birthplace (State or Foreign Country) Columbia If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) **Funeral** Months Days XXX M 2□ F Yrs. Director July 29, 1917 218-12-8452 Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No Director Maryland Howard County Columbia 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10600 Shaker Drive 21046 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12 Yes 2 10 If Yes, Give Year or Dates: 1934-1940 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 ™idowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) pemit. Pages 1 and 2 should be filed within Department of Health and Mental Physiene. Important: If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) mutual clerk/farmer racetrack 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Herbert Melvin Brown Grace Elizabeth Stromberg 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ms. Pam Prescott/daughter 6755 Flapjack Lane, Columbia, MD 21046

20b. Place of Disposition (Name of cemetery, cremetory or other place)

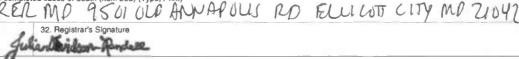
Date

20c. Location - City 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State ö 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Gdn 11MAR98 Marriottsville, MD 21 Signature of Funerel Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Betw Onset and Death **Physician** /Medical Immediate Cause (Final CEREBRAL INFARCTION disease or condition resulting In death) Examiner attanding physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or es a consequence of) Physician/Medical Due to (or as e consequence of) Part II. Other algalificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? Records, P.O. 1 Ves 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE þ 24b. Were autopsy findings available prior to completion of cause of death? CARCINOMA OF THE LARY NX 24a. Was an eutopsy performed? Completed peeu Division of Vital 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: Aftar 1 Natural 5 Pending investigation daath. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A complataly filled in by the fo 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

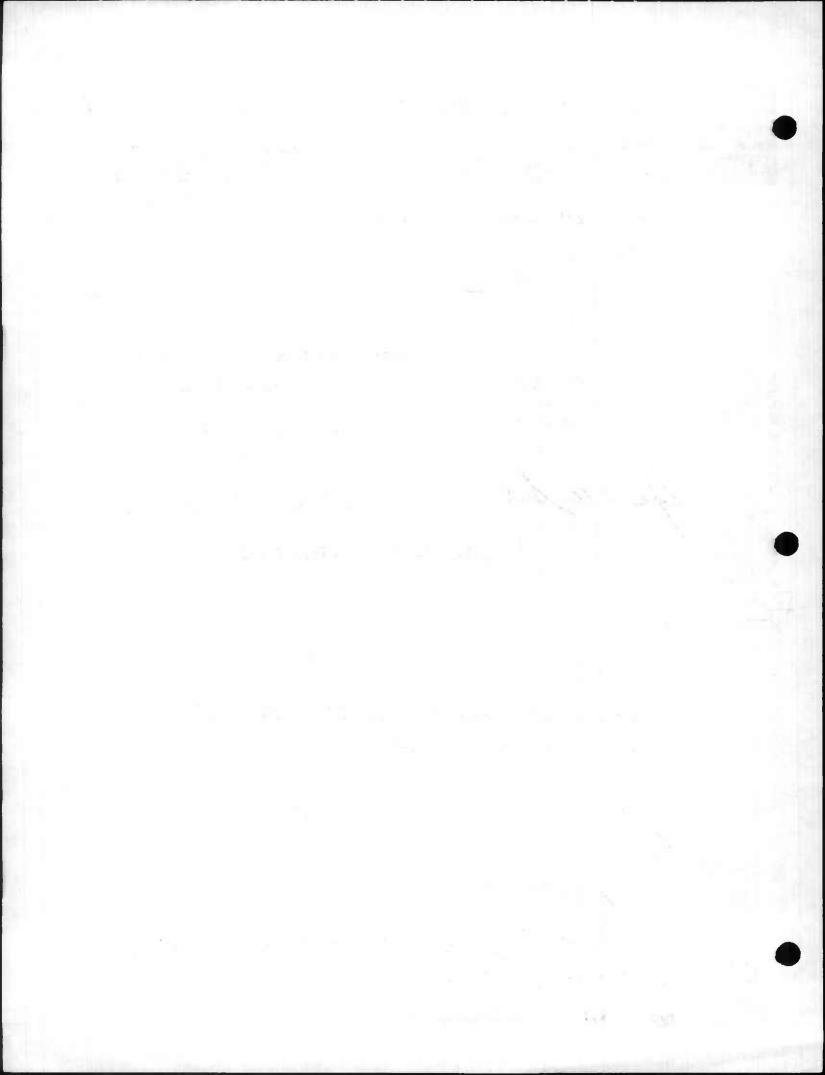
Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer)

State Registrar

31. Date filed (Month, Dey, Year)



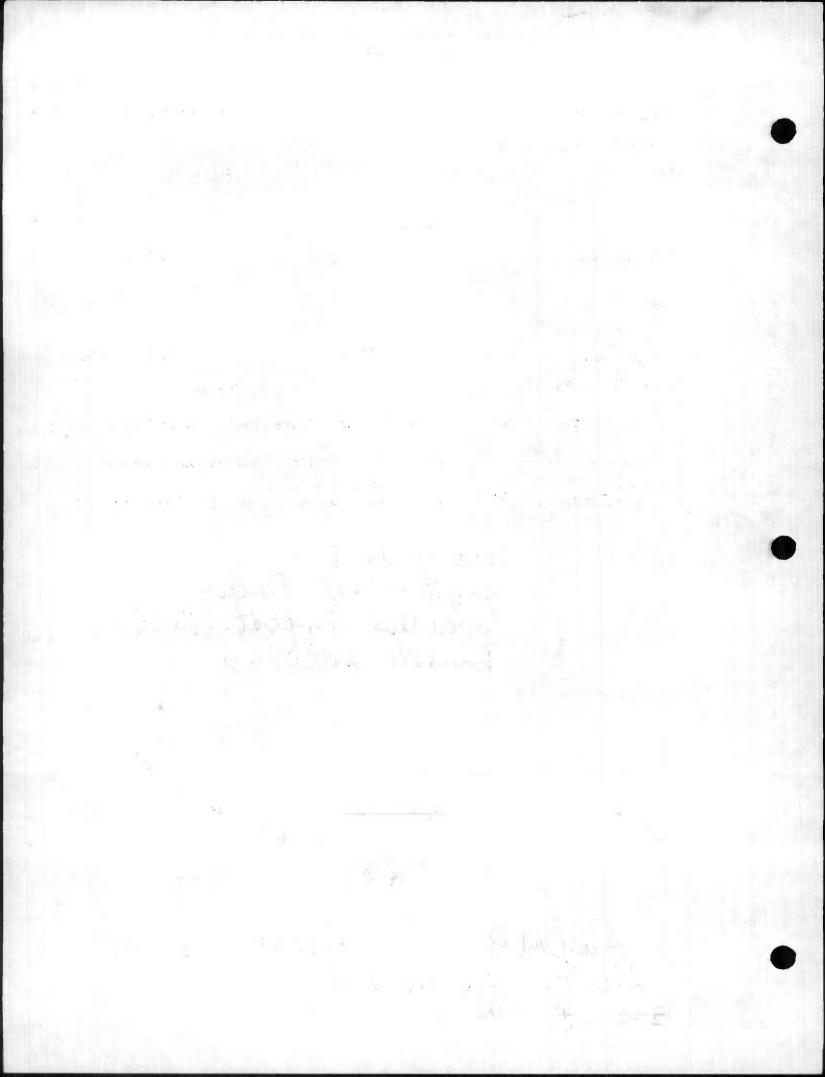
DHMH 16 Rev 6/95



Items: 26 Per MD,31 Per DB Film G-757 3-9-98RC Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Month Day Yaa **Physician** February 28, 1998 5:15 P.M. William Brooks
4a Facility Nama (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A 2802 Ruscombe Lane 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (Stata or Foreign Country) 5. Social Security Number 6. Sex 8. Data of Birth (Month, Day, Year) **Funeral** 10 M 20 F Days Months Hours Min Md 216-07-2902 85 Yrs. Director 12-17-1913 Usual Rasidence of Dacedant with the Maryland 10d. Insida City Limits 10a. Stata 10b Counts 10c. City. Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Magical Examinat must be notified as 1 ☐ Yas 2 ☐ No Director Md N/A Baltimore 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? 2802 Ruscombe Lane USA 21215 Funeral 72 hours after death 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc 1 Naver Married 2 ☐ Married Maryland 21215-0020 1 Yas 2√No Specify: If Yas, Giva Yaar or Dafes: Specify: Black 2 3X Widowed 4 □ Divorced 16a. Dacedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important If Item 27 is marked other than "n any injury or other traumatic event, the Med annex. Elamantary/Sacondary (0-12) Collaga (1-4or 5+) Clerk 12th grade Post 2 Years Office 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Thomas H. Brooks Mary M. Chambers 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ratationship (Type, Print) Amy B. Matthews- Sister 9252 Howard Square Drive Pikesville, Md 21208 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Cedar Hill Cemetery 3-5-98 Anne Arundel Co, Md 21. Signature of Funeral Service Licensee 22 Nama and Address of Facility
March F/H West 4300 Wabash Avenue Baltimore, Md 21215 Approximata Interval Batween Onsat and Daath Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evenings.) physiolan at a the burish Box 68760. certificate be Physician/Medical that initiated events resulting in death) Last attending that the death 3 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use gaetribute to the cause of death? ŝ signed by t Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed law. **D8082** 788 The 262 No 1 □ Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital Physician: 25. Was case referred to medical 8 26. Place of Death (Check og) one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 10 1 Yes 2 No 1 [] Inpatient 1 funeral 28a. Date of Injury (Month, Day Year) 26c. Injury at Work? 28d. Describe how injury occurred Certification: Manger of Death 28b. Time of Affer Natural Attending 5 Pending 1 Yes 2 No death. To the Hospital or Attends within 24 hours after death To the Funeral Director: A investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At hor building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29s. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fitie of certifie 30. Name and ss of person who complated causa of death (Itam 23a) (Type, Print) ruey ara 31. Data filad (Month, Day, Year Registrar's Signature, Fundan Fundale

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath innie turch of Maryland Medical System Balti of Maryland Medical System Balti 7 Ana (In vrs. last birthday) If Undar 1 Yaar I VI Undar 24 Hrs. 4a. Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Daath N/A University Balti more 5. Social Security Number Birthplaca (Stata or Foraign Country) 217 12 32 62 Usual Rasidance of Dacadent 1 M 2 T Yrs. 9-30-05 acyland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Mariland Baltimore 1 TYS 2 No Director 10e. Straat and Number 10f. Zip Coda 10g. Citizen of What Country 2 05 Ve 12. Was Dacedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 € No If Yas, Giva Yaar or Datas: 11. Marital Status Was Dacadant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. 1 Never Married 2 Marriad 1 Yas 2 No Specify: 3 Widowad 4 Divorced Specify: Completed 15. Decedant's Educetion 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working "__lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry (Spacify only highast grada complated) Eiamentary/Secondary (0-12) College (1-4or 5+) 5th Grade 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middla, Maldan Sumame) Elizabeth ermiah 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Anna Rutland Baltimore Md. 21205
ata 20c. Location - City or Town, State tantielo 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Lion Cem. 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility 21202 23a Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Bult. md. Approximate Intervei Between Onset and Death Immediata Cause (Finei 2100 disaesa or condition rasulting in daath) tasciitis Necroti Zi INKNOWN Dua to (or as a consequence of) Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Disaasa or injury that initiated avents rasulting in death) Last Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? chronic rend insufficiency 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of ceusa of daath? 24a. Was an autopsy performed? Hypertension atrial fibrillation 2 NO 1 Yas 1 ☐ Yas 2 ☐ No 25. Was cese refarred to medical examiner? 26. Place of Death (Check only ona) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatiant 3 DOA 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred

/Medical Examiner Physician/Medical Examiner P.O. Box 68760, certificate be of Vital Records, Completed Be 10 this Certification: dling

Physician

/Medical

Examiner

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Director

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Department of Health of Important: If Item 27 is any injury or other tra

Physician

Baltimore, Maryland 21215-0020

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29a. Cartifian

(Check only one) 29b. Signatura and titla of cartifiar

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2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa numbar 29d. Data signed (Month, Day, Yaar)

30. Nama and address of parson who completed cause of daath (Item 23e) (Type, Print)
Katherine V. 22 South Gre 22 South Greene St. Baltimore, Maryland 21201 hatherine

State Registrar

Medical

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	Nama and address of person who Recet MD 49	complated causa of das			MA - /	,				

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month March 5, Ruth A. 1998 Bruhn 8:20 a.m. 4e. Facility Nema (If not institution, give straat and numbar) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Deys Hours 1□ M 2□ F Yrs 217-03-1632 July 14,1912 Maryland Usual Rasidance of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Baltimore Glen Arm 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 11630 Glen Arm Road #U 13 21057 U.S.A. 12. Wes Dacedant Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - Amarican Indian, Black, White, etc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yeer or Detes: 1 Never Marriad 2 Married 1 Yes 2√2 No Specify: Specify 37 Widowed 4 Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadant's Education (Specify only highest grade complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) University of Md. 2 yrs. Clerical 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maiden Surname) John Schmauss Katherine Sanger 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mrs. Nancy G. Bowen/Dtr 550 Allegheny Ave. Towson, Maryland 21204 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Burlal 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Parkwood Cemetery Parkville, Maryland 21. Signature of Funeral Service Licensas 22. Nama and Address of Fecility 1050 York Road a. Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Entar tha disam shock, or haart failure. the ns thet caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, Approximata Intarval Between Onsat and Death und dis upse End-Stage Immediata Ceuse (Finel 2 /2 years disaasa or condition rasulting in death) Dua to (or as a consequence of) Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dtd tobacco use contributa to the causa of death? 1 Yes 25 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 1 Yes 2 No 26. Placa of Daath (Chack only ona) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 8 NOthar (Specify) 28d. Dascribe how Injury occurred 28b. Tima of 27. Manner of Death 1 Natural

Physician /Medical **Examiner**

signed by t d be detech

by

Completed

Be

2

Certification:

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Directo

by

Completed

Funeral

Director

7 is marked other than "naturel", or fems 23s or 28s-f show traumstic event, the Medical Examiner must be notified at

pemit. Pages 1 and 2 should be filed withir Department of Health and Mentel Hygiane important: if item 27 is marked other than any injury or other traumatic event.

105/98 8:20Am

ician and buriel-transit Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury thet initiated avants rasulting in death) Last physician s the buriel Physician/Medical

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5 Pending invastigation 6 Could not be datarmined 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28f. Location (Straat and Number or Rural Route Number, City or Town, Stata)

29a. Certifier

2 Accidant

4 - Homicide

3 ☐ Suicida

To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) end manner stated.

29b. Signature and talk of careful

29c. Licansa number

29d. Data signed (Month, Day, Year)

State

Registrar

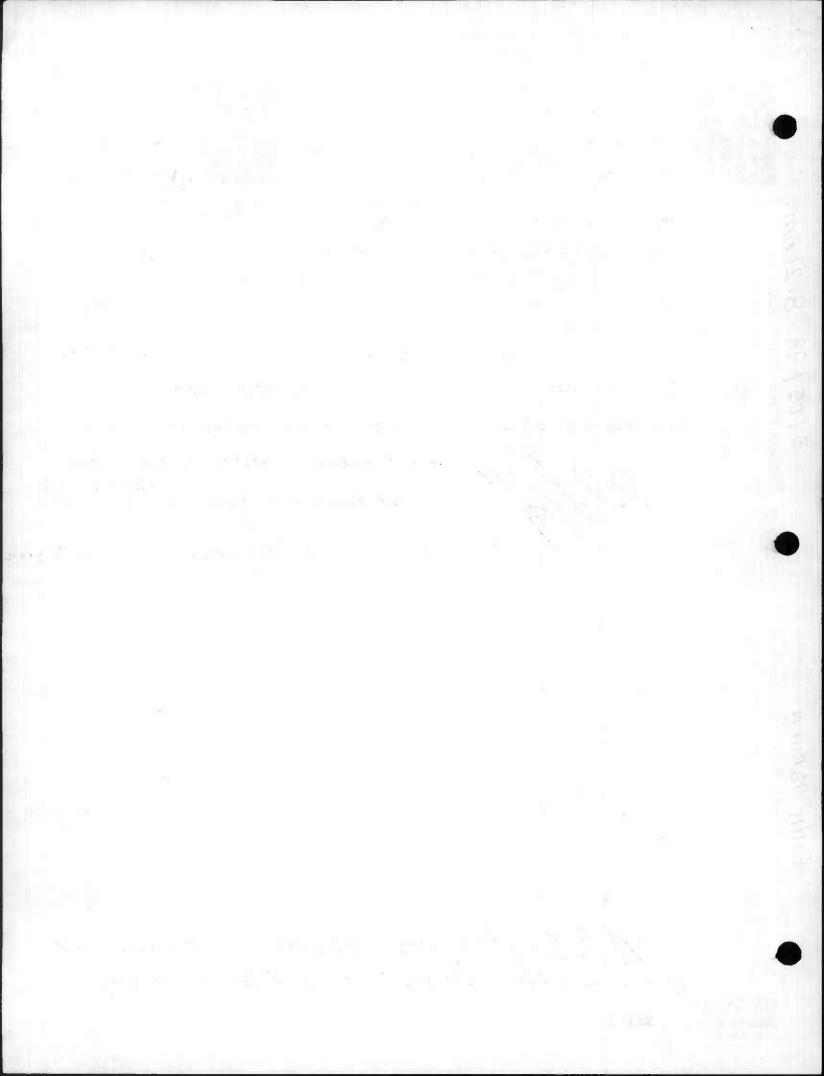
30. Nema end address of person who completed cause of the (Itam 23a) (Typa, Print)
11). A. Kiley GBMC 6701 N. Charles St. Balto. MJ 21204 31. Dete filad (Month, Dey, Year) AR 09

32. Registrar's Signature ula Savidson-Randolle

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: within 24 hours efter death.

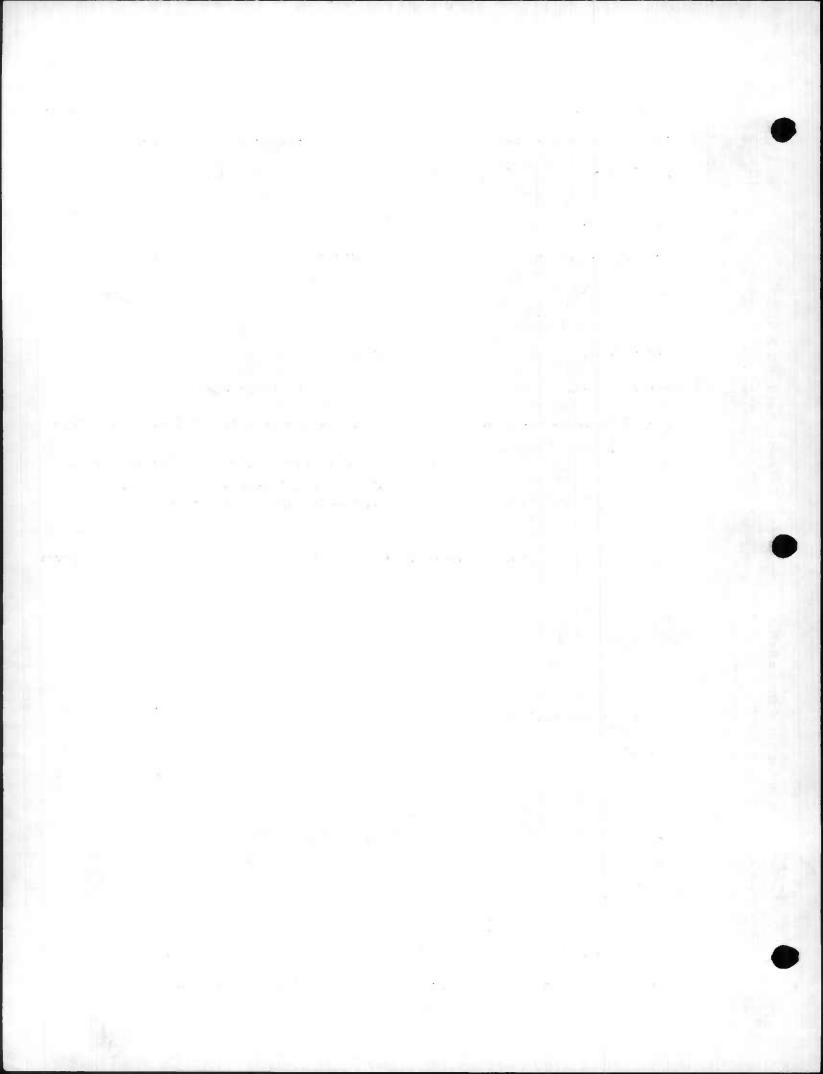
To the Funeral Director: After this certifica



State of Maryland / Department of Health and Mental Hygieneg 8 07262

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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Albert Frederick Bleinberger 0210 mar /Medical 4a. Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSP Baltimore N/AIf Undar 1 Yaar Months Days If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Hours 129 M 2□ F 78 219-05-5136 Yrs **Director** April 7, 1919 Maryland Usuai Rasidance of Decedent the Marylend 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at XXYas 2 No Maryland N/A Baltimore Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? With 316 S. Augusta Avenue 21229 United States permit. Pages 1 and 2 should be filed within 72 hours effer death to Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or hame 20-eny injury or other traumett. Funeral 12. Was Decedent Ever In U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Spacify Yes or No-if Yes, specify Cuben, Maxican, Puarto Rican, atc.) Race - American Indien, Bleck, White, etc. 1 ☐ Yas 2 Ž No If Yas, Giva Yeer or Datas: 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 4 No Specify: White à 3 Nidowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collaga (1-4or 5+) Landscaping Landscaper 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumame) Elizabeth Mary Muellen Frederick Henry Bleinberger P 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 316 S. Augusta Ave., Baltimore, MD 21229 Marlene Nash / Daughter Baltimore, 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlai 2 ☑ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 3/9/98 Ft. Lincoln Crematory Brentwood, MD 21. Signature of Funarai Sarvice Licensee 22. Nama and Address of Fecility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta intarval Batween Onset end Death **Physician** /Medical immediata Ceusa (Final disaasa or condition rasulting in death) neumonia **Examiner** Dua to (or as a consequence of) Examiner nding physician and use es the bunel-transit Sequantially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Diseasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consequance of): Physiclan/Medical Due to (or as a consequance of): signed by the etter Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Seizure Disorder à 24b. Ware autopsy findings evailable prior to completion of cause of daath? been si 24a. Was an autopsy performed? Completed Dementro CVA After this certificate 1 ☐ Yas 2 ☒ No 1 Yes 2 No funeral director, 25. Was casa refarred to medical axaminar? 8 26. Placa of Death (Check only ona) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yas 2€No 28a. Data of injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. injury at Work? 28d. Dascribe how injury occurred Certification: Division 5 Panding 1 XNatural 1 ☐ Yas 2 ☐ No invastigetion 2 Accident Director 6 Could not be determined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Piace of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide hours Certifying Physician: To tha best of my knowledge, death occurred et the tima, data and place, and dua to tha causa(s) and manner as stated.

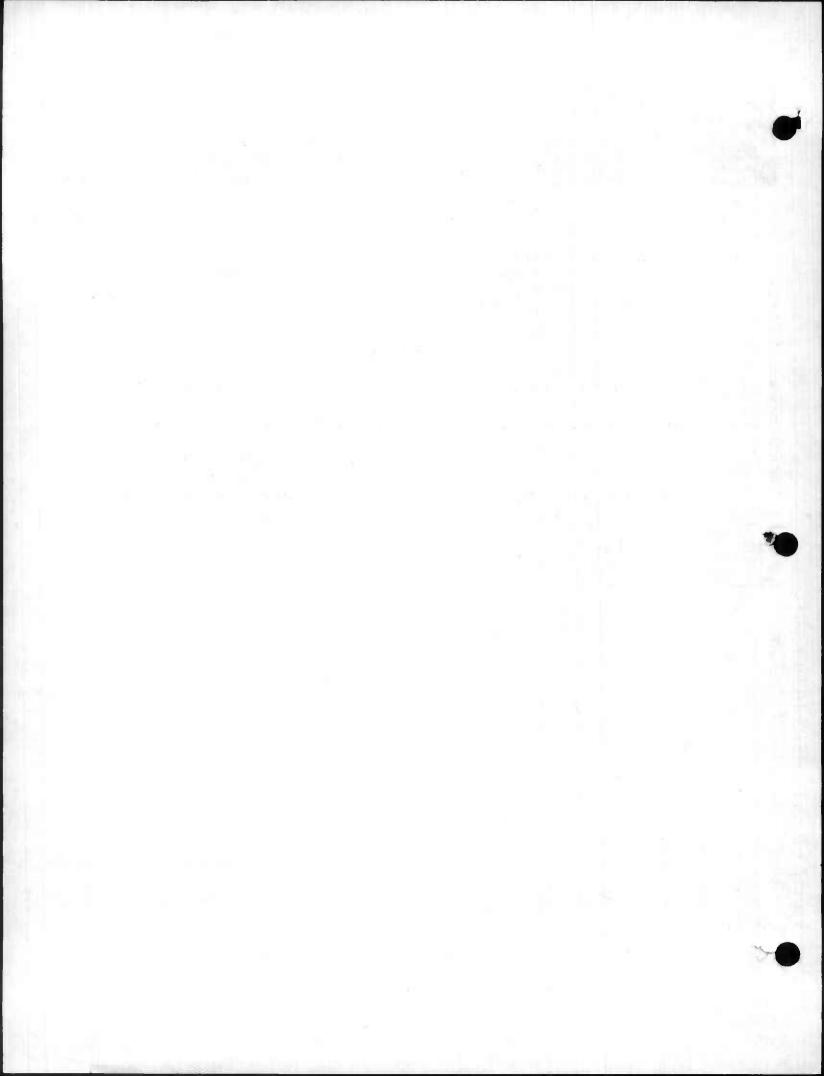
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the causa(s) and mennar stated. 29a. Certifian 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) M.D. 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) ST AGNES HOSP Baltimore Bernare Mickelson 32. Hogistrary Signature
Scha David M. Rendelle 31. Data filed (Month, Day, Year)
MAR 0 9 1998 State Registrar

DHMH 16 Rev 6/95

EIN BERGER

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NAME



P.O. Records, of Vital

235-96-5895

DEBORAH BOOTH

21215-0020

Baltimore, Maryland

Box 68760. or Attending Physician: After Division efter death. To the Hospital of within 24 hours e To the Funeral D

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funeral

illed in by

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27. Manner of Daath

1 Naturel 2 ☐ Accidant

3 Suicide

29a. Certifier

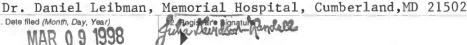
4 - Homicide

29b. Signetura and alle of paddier

31. Dete filed (Month, Day, Year) MAR 09

5 Pending investigation

6 Could not be detarmined



28b. Time of

28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

15 Certifying Physicien: To the best of my knowledga, deeth occurred et tha tima, data and placa, end due to the ceusa(s) end mannar es stated.
2 Medical Examinar: On the basis of axamination end/or investigation, in my opinion, daeth occurred et the time, dete end placa, end dua to tha cause(s) and manner steted.

29c. License number

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28d. Dascribe how injury occurred

Location (Straet and Number or Rurel Route Number, City or Town, Stete)

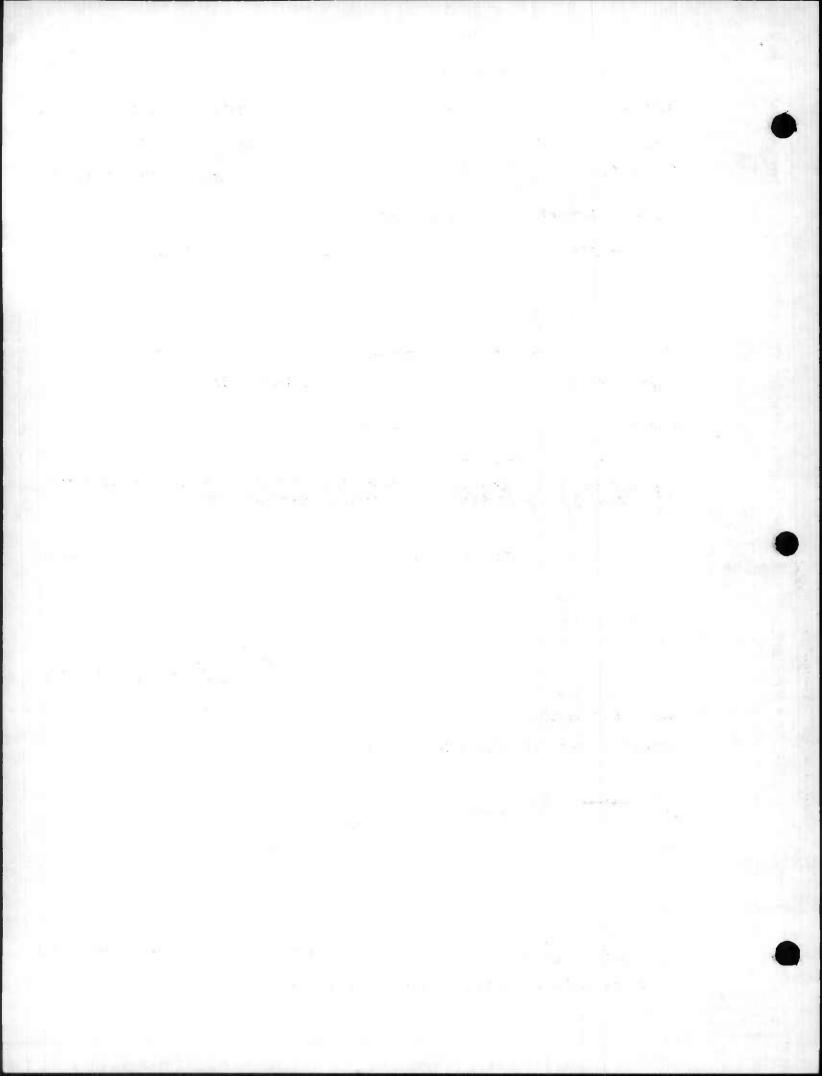
29d. Date signed (Month, Dev. Year)

February

1998

28a. Dete of Injury (Month, Dey Year)

30. Neme end address of person who completed ceuse of daeth (Itam 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygien®

Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month MARCH **Physician** MARCEL 04139 AM COLEMAN, 6, 1998 /Medicai 4a. Facility Nama (If not Institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Daath Examiner MERCY MEDICAL CENTER BALTIMORE BALTIMORE CITY 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) 5. Social Sacurity Number 6. Sex 9. Birthplaca (Stata or Foraign **Funerai** 1 XM 2□ F Hours Min. n/a FEBRUARY 18, ME Maryland Director 16 Usual Rasidance of Dacedant 10a Stata 10b. County 10c. City, Town or Location tem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, its Marical Examiner must be notified at 10d. Inside City Limits MD n/a Baltimore Director 1 Yas 2 No 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1604 Shadyside Road 21218 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, White, atc. 1 Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Spacify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decadant's Education
(Specify only highast grada complated) 16b. Kind of Businass/Industry Hyglene. Elementery/Secondary (0-12) College (1-4or 5+) n/a n/a n/a is marked other permit. Pages 1 end 2 should be filk Department of Health end Mentel Hy Important: if them 27 is marked othen any injury or other traumatic event 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Marcel T. Coleman 2 Cherie A. Brown 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, State, Zip Coda) Cherie A. Brown 1604 Shadyside Road, Balto., MD 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Steta IX Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata King Memorial Park 3/10/98 Randallstown, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licens 22. Nama and Addrass of Facility
LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO.MD21207 not antar tha mode of dying, such as cardiac or respiratory errest, Approximete Intarval Betwaan Onsat end Death **Physician** Immadiata Cause (Final disaesa or condition resulting in daath) /Medicai ELECTRO MECHANICAL DISSOCIATION Examiner Due to (or es e consequança of). RENAL FAILURE Saquantially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disease or Injury that initiated avents rasulting In death) Last Dua to (or as a consequence of): Box 68760 3 days physicians the burns PULMONARY HYPERTENSION 90 Physician/Medical Dua to (or as a consaquance of): HYPOXIA o P.O. 1 signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Extremely Low Birth Weight, Intrauterine Growth Records, 24b. Wara autopsy findings evaileble prior to complation of causa of deeth? Completed 24e. Was an autopsy parformad? Retardation, Ambiguous Genitalia, Hypotension 1 Yas 2 No 1 Yas 2 No Division of Vital 25. Wes case refarred to madical axeminar? Be 26. Placa of Deeth (Check only one) Hospital: 1 Inpatiant 2 □ ER/Outpatiant 3 □ DOA Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 2 1 Yas 2 No 27. Menner of Deeth 28c. Injury at Work? Medical Certification: 28b. Tima of 28d. Describe how injury occurred 1 Natural 5 Panding invastigation i or Attending effer death.

I Director: Aft din by the fur 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be 3 Suicida 28a. Piaca of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Straet end Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled is Certifying Physician: To the beat of my knowledga, death occurred at tha time, date end plece, and dua to the cause(s) end mannar as statad.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar statad. 29a. Cartifier 29b. Signatura and the of cartifiar 29c. Licansa number 29d. Data signad (Month, Day, Year) 3/6/98 22 South Greene St. NSW65 30. Nama end eddrass of parson who complated cause of death (Item 23a) (Type, Print) University of Maryland Medical Center Tinothy W. Palmer, MD Baltimore, MD 21201 31. Data filed (Month, Day, Year) 32. Registrar's Signature State he Augdson-Randell MAR 0 9 1998

Registrar

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the distribute

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 3/3/98 Day **Physician** SHEILA CARROLL 12255 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Desth Examiner BALTIMORE 838 NORTH STRICKER ST. (HOME) 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2♥F Months Days 49 5/27/1948 Director 216-52-1898 Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental Hygiene. Inter if Health and Mental Hygiene. Interest 27 Is marked other than "natural", or items 23s or 28s-f show any or other traumatic avent, in alreading Experimer man be notified at any or other traumatic avent, in alreading Experimer man be notified at 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐¥Yes 2 ☐ No Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 838 N. STRICKER ST. USA 21217 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0020 Specify: SpecifAFR. AMERICAN by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) CAFETERIA ATTENDANT BALTO.CITY SCHOOLS 18. Mothar's Name (First, Middle, Maidan Sumama) 17. Father's Name (First, Middle, Last) Be WILLIAM CARROLL ALETHIA A. CARROLL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) DENISE CARROLL (SISTER) 129 W. CROSS STREET BALTO. MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 D Burial 2 Cremation 3 Removal from State MT. CALVARY CEM. 7/MAR/1998 BROOKLYN 4 ☐ Donation 5 ☐ Other (Specify) ESTEP BROTHERS FUNERAL HOME P.A. 21. Signeture of Funeral Service Licenses 1300 EUTAW PL. BALTIMORE, MD. Pert1. Enserthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** alledie a Immediate Ceuse (Finel diseasa or condition rasulting in death) Cancer 2 sems Examiner Examiner Sequentially list conditions, if any, laading to Immediate cause. Enter Underlying Causa (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai the Dua to (or as a consequence of) The law requires that the deeth certificals signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Comestine Henry P 24b. Were autopsy findings svallable prior to completion of cause of daath? Completed 24e. Was an autopsy irector, page 2 s 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifice stely filled in by the funeral director. 25. Was cese referred to medicel examiner? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Invastigation 1 ☐ Yas 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Spacify) in 24 hours. the Funeral Direct 4 Homicide Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Cartifian To the Hosp within 24 hou To the Fune completely fil Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D40854 1 M 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 301 St Part P1 Bultura 21202 A 4027 Durch MO

Registrar

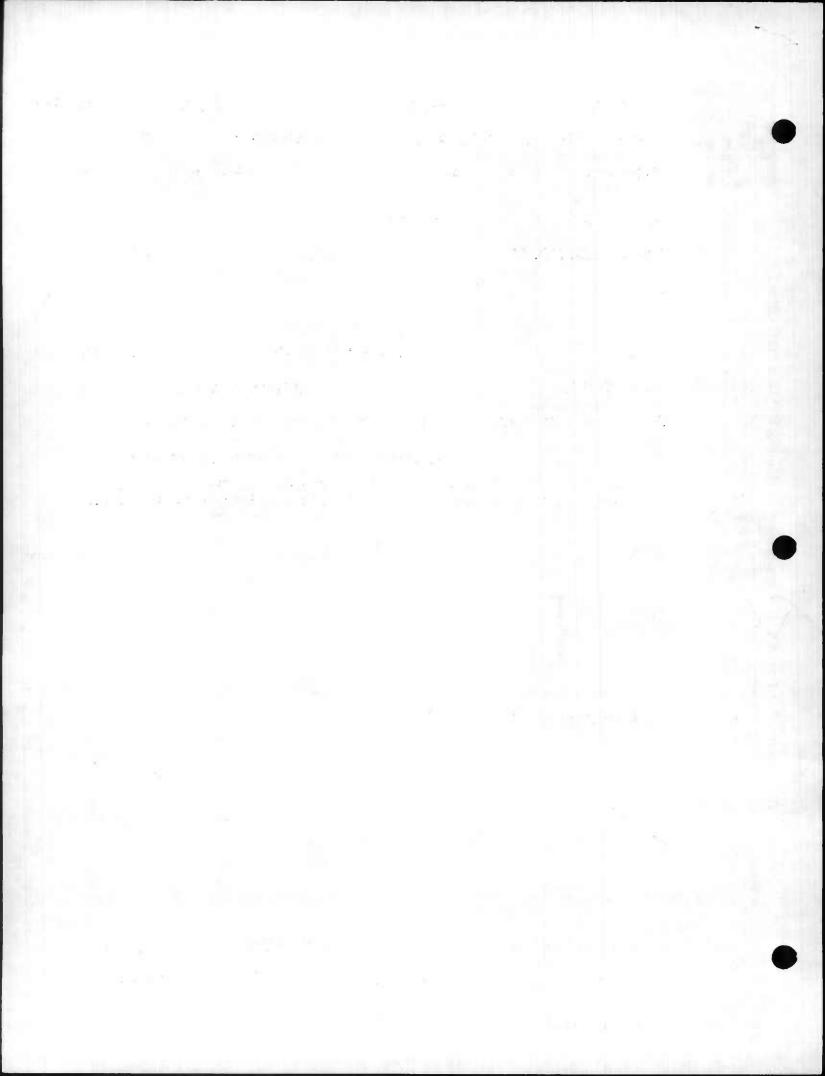
State

MAR 0 9 1998

31. Date filed (Month, Day, Year)

32 Registrar's Signature Julia Savidson-Randelle

DHMH 16 Rev 6/95



Items: 10a,10c PER FH Film G-757 3-9-98RC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Item#1 per Phy,#6 per FH G757 3/31/98 EW 1. Decedant's Name (First, Middla, Last) 2. Dafa of Deeth 3. Time of Death Month **Physician** MARCH 4, JULIA -A. E. CROWDER 1998 18:10 /Medical 4e. Fecility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SAINT AGNES HOSPITAL, 900 CATON AVENUE 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Dafa of Birth | Months | Days | Hours | Min. | MAY 27, 1921 BALTIMORE Birthplaca (State or Foraign Country)
 MD 5. Sociel Sacurity Number **Funeral** ₩ 2× F 414-50-3607 Director Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or Itema 23a or 28a-f shov Examiner must be notified at Tennessee Franklin XXYes 2 No Director N/A BALTO 10e. Sfreef and Numbar 10f. Zip Coda 10g. Citizan of What Country? 4229 CROWDER 37064 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuben, Mexicen, Puarto Rican, atc.) Race - Amaricen Indian, Biack, Whita, etc. 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 ☐ Navar Merriad 2 ☐ Married 21215-0020 "natural", or 1 ☐ Yas 2 X No Specify: Specify: BLACK à 3 X Widowed 4 □ Divorced be filed within 72 houts! Hygiena.
d other than "natura Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOL COOK 8th N/A Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event page. 17. Fafhar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be JOHN ROBERTS LIZZIE MCEWEN 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 20b. Place of Disposition (Nama of cometery, cramefory or other place)

3905 GWYNN OAK AVE BALTO, MD 21207

20c. Location - City or Town, Stete WILLIAM MCGAVACK 20a. Mathod of Disposition He Burial 2 Cramation 3 Ramovai from Stata 4 Donation 5 Othar (Spacify) RENOLDS CEM 1998 WILLIAMSON CO, TENN 21. Signature of Funeral Sarvice Licensae 22. Nama end Addrass of Facility ETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213 PATTON BRO FH 23a. Parl 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrast,

Approximate Interval Batween Onset and Death

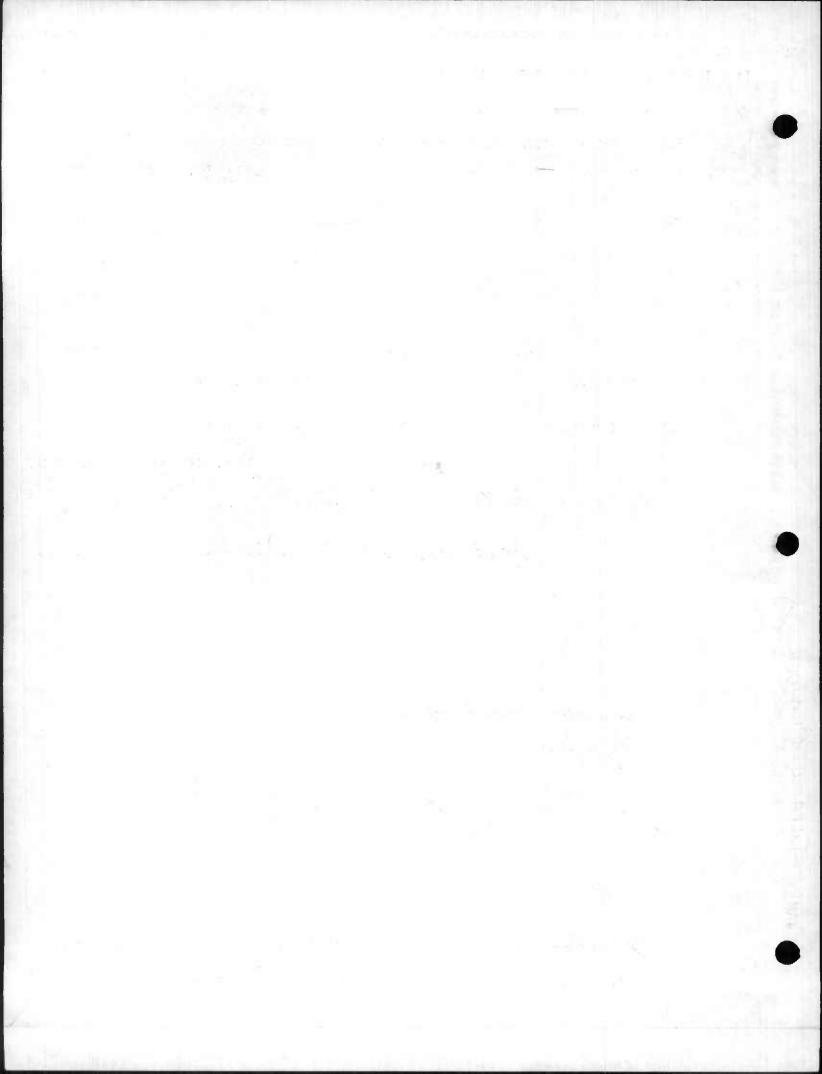
Onset and Death Physician teuse Myocardial In faction /Medical Immediate Ceusa (Final 1 Www disaasa or condition rasulting in daath) Examine Examiner Sequentially list conditions, if eny, laeding to Immadiata causa. Entar Undarlying Causa (Disaase or injury that Initiated events rasuiting in death) Lesf Dua to (or as e consequence of): physician Physician/Medical the Dua to (or as e consequence of): 980 Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Completed by 24a. Was an autopsy parlormed? 24b. Wara autopsy findings avsilable prior to completion of ceuse of death? page 2 s 1 ☐ Yas 2 ☐ No 1 Yas 2 No certificate Attending Physician: Be 25. Was cesa rafarred to medical 26. Placa of Death (Check only ona) 1 Yas 2 No Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred 28b. Tima of After 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At homa, farm, straaf, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stata) 4 Homicida ò 24 hours a 29a. Cartifiar 1 Certifying Physicien: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of certifi-29d. Date signed (Month, Day, Year) March 4, 1988 parson who complated causa of death (Itam 23a) (Type, Print)

900 Caton Avenue Bulturoro, May land

SCRUGGS MO)

filed (Month, Day,

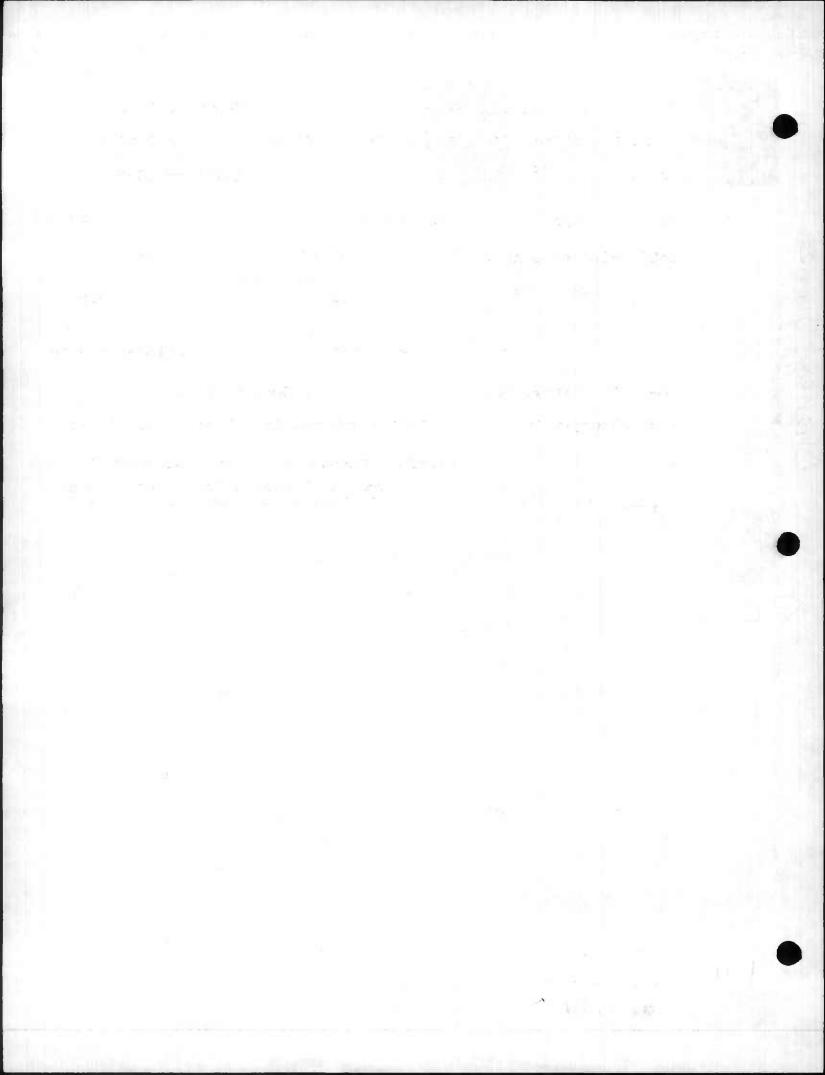
32. Begistrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

					Certi	ficate o	f Death		Reg. No.	0 0	1200
hysician		Decedent's Neme (First, Midd	le, Last)					2. Dete of De Month	Dev	Yeer	3. Time of Death
/Medical	ŀ	James E.	Chaney,					MARCH	5, 19	98	1:44PM
xaminer	ľ	le. Facility Neme (If not institution					4b. City, Town, or	Location of Deeth			
_		GREATER BAL					TOWSON			IMORE	,
neral ector	1	5. Social Security Number 216-34-3342 Usuel Residence of Decadent	6. Sex 7. A	ge (In yrs. le:	V . 1	If Under 1 Yes Jonths Dey		(Month, De	th ly, Year) 22, 19	Country	ce (State or Foreign y) MD
ahow sd.at	1	Oa. State 10b. County		10c. City,	Town or Loca	tion				10d	d. Inside City Limits
notified at		MD n	/a	Ba	altimo	re					Yes 2□ No
be notified Director		0e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Country	17
		6608 Birch	wood Ave.			21	224		USA	A	
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aver aver		7. Fether's Neme (First, Middle,	Last)				18. Mother's Na	me (First, Middle,	Maiden Sumen	ne)	
To B		James E. Ch						othy Ho			
1 2		19e. fnforment's Neme/Reletions	_				et end Number or R				ode)
other t	-	Hazel Chaney	/wife	201 21			wood Ave				224
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ician	١	ahook, or heert failure. List	only one cause on each i	ine.			, ,			In	nterval Between Onset and Deeth
dical	1	mmediete Ceuse (Finel	601		4.700					1	1 m > 10 C
niner	U	diseese or condition resulting In death)	e CORON		ALIN es e conseque		ASE				10425
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EX EX		Sequentially list conditions, freely, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury	c. 01232							- 2	DIES
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0 5 1 - 1	2	7. Menner of Deeth 1 Paturel 5 Pendir 2 Accident Investi 3 Sulcide 6 Could	pation	ary Year)	8b. Time of Injury	28c. fnj W M 1[ury et ork? Yes 2 No	28d. Describe t	now Injury occur	red	
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completely filled Medical Ce	2	29a. Certifier 1 ☐ Certifyir (Check only one)	g Physictan: To the best Examiner: On the basis o end menner st	f exemination	edge, death or n end/or inves	ccurred et the tigetion, in my	time, date end piece opinion, deeth occu	e, end due to the erred et the time,	cause(s) and me date end plece,	enner es etete end due to th	ed. 16 cause(s)
Comple	2	9b. Signature end title of certifie				29c. Licer	nse number		29d. Date signe		y, Year)
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1+1	3	0. Name/end eddress of person	who completed cause of o	deeth (Item 2	3a) (Type, Pri	ot)	us st B	ALT, MD			
State	3	1. Dete filed (Month, Day, Year)		ar's Signetur				i			
egistrar		MINITARY U.S. 125	D June	m14001/	more						

Chaney, James



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death 3/9/98 reb Item:1 per M.D G-757 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth antai

N/A

9. Birthplece (State or Foreign Country)
Baltimore, MD

White

21222

21222

Approximate intervel Between Onset end Deeth

24b. Were autopsy findings eveileble prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

10d. Inside City Limits 1 ☐ Yes 2 No

Physician /Medical Examiner

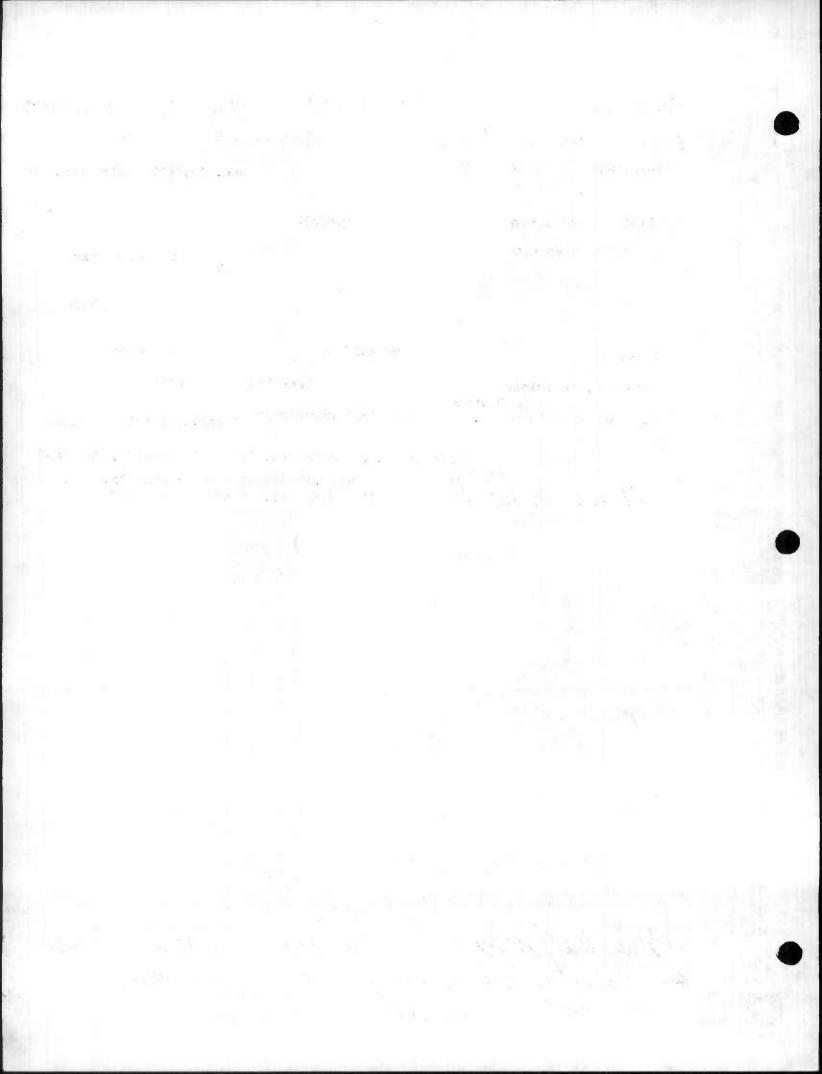
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CIL Nathalie 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltionov 0 MUSINS home Drien 8. Date of Birth (Month, Day, Year) Aug. 30,1930 If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1 □ M 2 ☑ F 217-26-1864 67 Yrs. Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show 10e. Stete 10b. County 10c. City, Town or Location Director Dunda1k Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? reast be n 21222 8195 Park Haven Road United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. treumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 21215-0020 8 1 Yes 2 No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced f Yes, Give reer or Dates: "natural". 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 11 Years other permit. Pages 1 and 2 should be file Department of Health and Mental Hyg important: If Nem 27 is merked other eny injury or other the second other than th Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Mary Williamson Charles B. Knoerlein 2 19e. Informent's Name/Reletionship (Type, Print) Husband 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8195 Park Haven Road Mr. Frank Cantalupo, Jr. Dundalk, Maryland Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other placa) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Sacred Ht. of Jesus Cem. 3/6/1998 Dundalk, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fugerel Service Licansee 22. Name and Address of Fechity neral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) emphysems Examiner Die to (or es e consequence of): Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68 76 Physician/Medical Due to (or es e consequenca of): The law requires that the death certifical attanding Pert ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t failure Kespivatory 1.27Yes 2□ No 3□ Probably 4□ Unknown þ should b Completed 24e. Wes an eutopsy performed? certificete 1 Yes 2₽No or Attending Physician: "after daath.

Director: After this certifice 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Menner of Deeth 28e. Dete of injury (Month, Day Year) 28b Time of 28c. injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accident in by the 3 Sulcide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a
To the Funerel D
completely filled Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end menner steted. 29a. Certifier Medical 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person wh completed cause of deeth (Item 23e) (Type, Print) Kadow (Dansis Hickory Ricke Rd

31. Dete filed (Month, Day, Year) State MAR 0 9 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene Q

				C	ertificate o	f Death	R	eg. No.	01210	
Dhania		1. Decedent's Neme (First, Middle, La	1.				2. Dete of Dea Month		3. Time of Deeth	
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how		10a. Stete 10b. County	1	Oc. City, Town or	Location				10d. Inside City Limit	
e Ma	cto	Maryland Baltimo	ore City	Baltim	ore				1 ☐ Yes 2 ☐ N	
72 hours efter death with the Maryland naturel, or Items 23e or 28a-f show are Examiner must be notified at steed by Funeral Director	al Dire	10e. Street end Number 5505 Bayview Circ	:le		10f. Zip Code 21224		1	0g. Citizan of V	Vhaf Country?	
	by	11. Marital Status 1 □ Nevar Married 2 □ Married 3 □ Widowed 4X □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	er in U,S.	3. Was Decedant of If Yes, specify Cu 1 ☐ Yas 2 ☑ N	f Hispanic Origin? (Suban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		e - American Indlen, ck, White, etc. :: White	
d within 72 hours ef giene. Ir than "naturel", or the Meutest Exem	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. De	cedent's Usuel Occ	supetion	rkina	16b. Kind of Bu	usiness/industry	
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ges 1 and 2 should be filed within 72 ho t of Health end Mental Hygiene. If item 27 is marked other than "nature or other traumatic event, the Meuteal To Re Commissed		19e. Informent's Na <i>me/</i> Reletionship (Jean Moore/neic	Type, Print) .e			nt Place,			Steta, Zip Code) Land 21211	
permit. Pages 1 and 2: Deperment of Health er Important: If Item 27 is any injury or other tree		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special	Removel from State	20b. Place of Di cemetery, o	sposition (Name of cremetory or other p	eleca)	Date	20c. Location -	City or Town, Stata	
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Physician		23a. Perf1. Enfer the disease, or com shock, or heart feilure. List only	plications that caused the	e death. Do not					Approximate Intervel Between Onsat and Death	
/Medical		Immediate Ceuse (Final disaese or condition	ASpiro	tion	preum	onia			4 WKS	
Examiner		resulting in death)		e to (or as e con						
D #	ne	_	COP	D					Years	
an and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events	Acut	e to (or es e con		luie			IWE	
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or Attending Physician: The effer death of the forest of the funeral director, part in by the funeral director in by the funeral direct	ToB	examiner? 1 ☐ Yes 2 No	Hospitel:	2 ER/Outpa	tient 3 DOA	Whor:	lome 5 ☐ Reside		er (Specify)	
Attending Physician: or death. ector: After this certific by the funeral director,		27. Menner of Death 1 ANetural 5 ☐ Pending 2 ☐ Accident investigatio	28e. Dete of Injury (Month, Day Y	ear) 28b. Tim Injui	y W		28d. Describe he			
al or Attending P s efter death. Il Director: After t ad in by the funers	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ее	28f. Location (Si City or Town		er or Rurel Routa Number,			
Hospital 24 hours e Funeral I tely filled Ical Ce	edicai (29a. Certifier (Check only one) Certifying Ph	nyalcian: To the best of miner: On the basis of ex and menner stetad	eminetion end/or	eeth occurred et the r Investigetion, in my	time, dete end plece y opinion, deeth occu	, end due to the carred et the time, d	ause(s) and me late end place,	enner es steted. end due to the cause(s)	
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To the Hos within 24 h To the Fur completely		30. Name end eddress of person who	completed cause of deat		ne Print)	6712 0H, MI	> 212		25-98	

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Registrar

31. Dete filed (Month, Dey, Year) MAR 0 9 1998

Strohen S.

29b. Signatura and title of certifier

Radentz 32. Registrer's Signeture wha Savidson Pandall

acis

30. Name and eddress of person who completed cause of deeth (Mem 23a) (Type, Print)

29c. License number

O.C.M.E

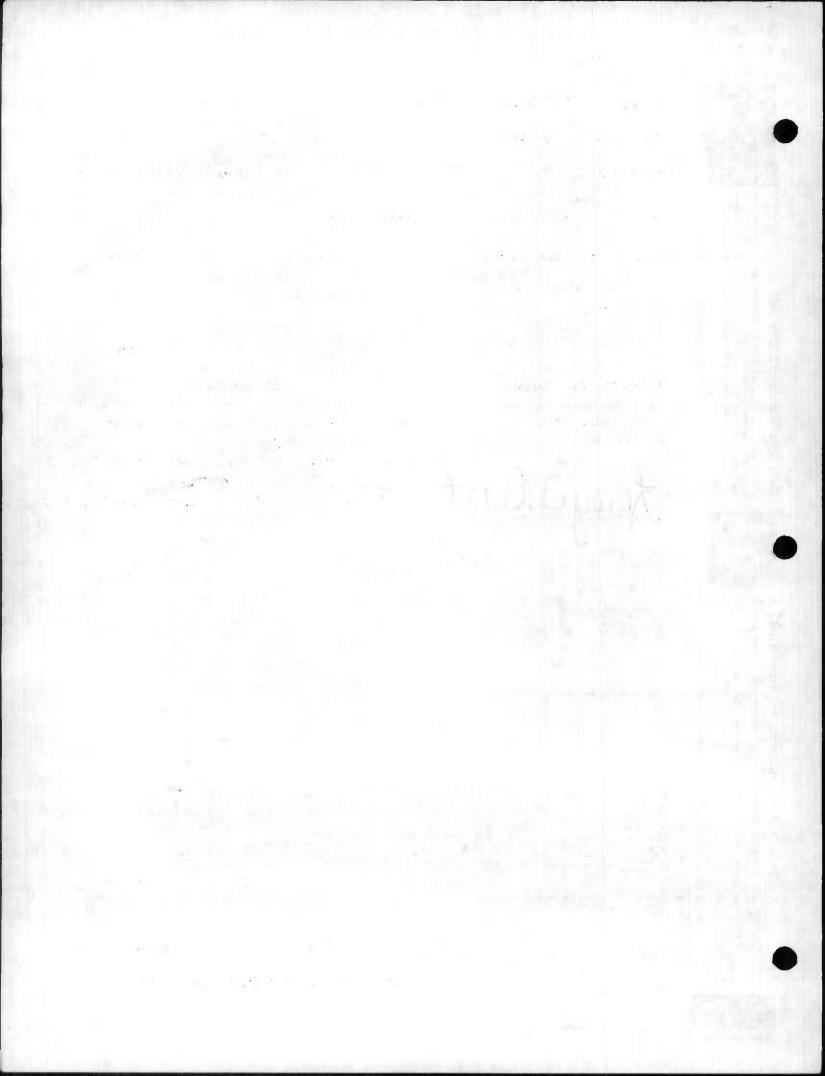
111 Penn Street, Baltimore, Maryland 21201

29d. Deta signed (Month, Dey, Year)

MARCH 3, 1998

DHMH 16 Rev 6/95

within 2 To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 5 per FH G-757 3/16/98 dh Certificate of Death Item: 1 per MD G-757 3/16/98 Reg. No. 1. Decedent's Neme (First, Middle, Last) Emma H. Dotterweich 3. Time of Death 2. Date of Death Month **Physician** March 8:45 PM 1998 6 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 1208 Francis Avenue Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. [Baltimore 5. Social Security Number 220-78-9595 214-46-019 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 耳F Yrs. 46-0184 Director 85 Nov 2, 1912 Maryland Usual Residence of Decedent tha Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No Directo Baltimore Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with neat of Health and Mental Hygiene.
Int: If Item 27 is marked other than "naturel", or items 23e or intro or other traumatic event, "It leads a feature in matter. 1208 Francis Avenue Funeral 21227 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Biack, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2□ No Specify: P 3√2 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Lambert R. Gittings Anna H. Mullen 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Carol A. Robinson, Daughter 1208 Francis Ave. Baltimore, MD 21227 20b. Placa of Disposition (Neme of cemetery, cremetory or other piece) 3-9-98 1 ☑ Burlal 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pagas Department of Important: If it eny injury or o Woodlawn Cemetery 22. Name and Address of Facility Ambrose Funeral Home, Inc.
1328 Sulphur Spring Road
Arbutus, Maryland 21227

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Pulmona, disease Examiner Due to (or es e consequence of): Examiner yo cardial attending physician and for use as the burial-transit tha death certificata be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of): signed by the a d be datached f 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Touchknown þ 24b. Were autopsy findings available prior to competition of ceuse Completed 24e. Was en autopsy cartificata has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Aftar 1 Maturel 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident or Attendation of the other. 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the ceuse(s) end menner steted. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number

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State Registrar nil 740 Maiden Choice lane Catonsville 32 negistras Signature Japan Landon Pandere

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

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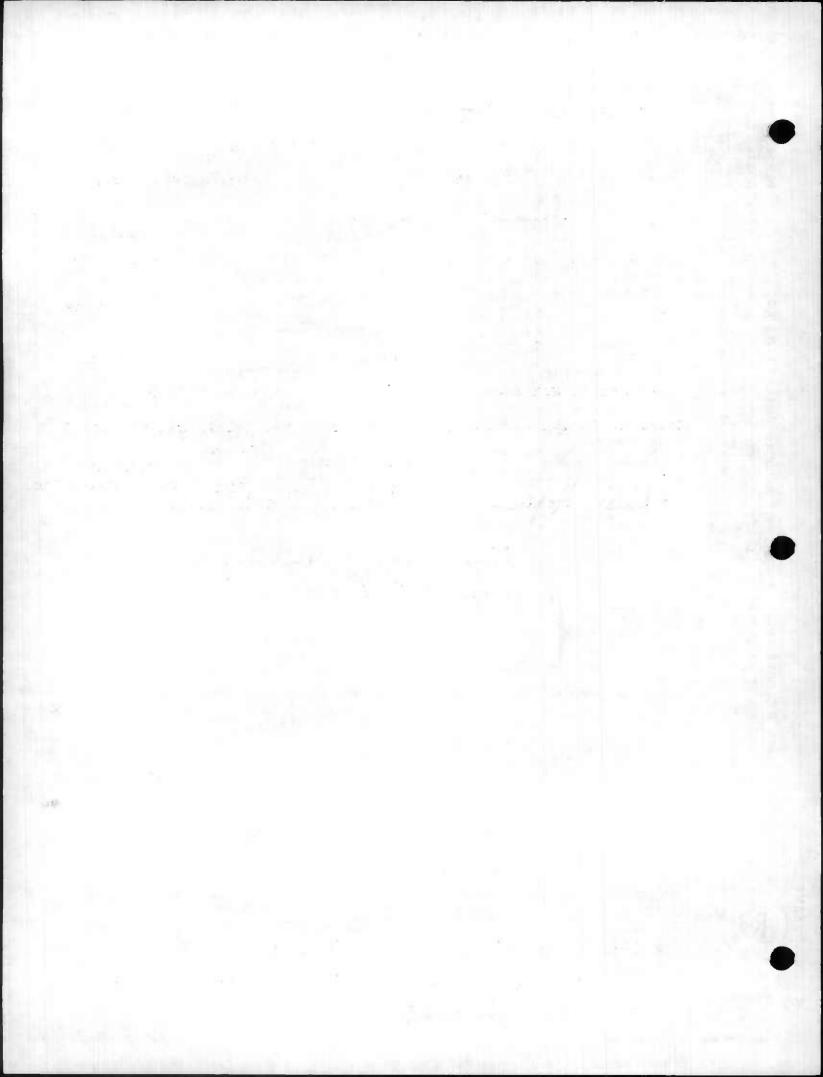
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31. Date filed (Month, Dey, Year)

March

1998

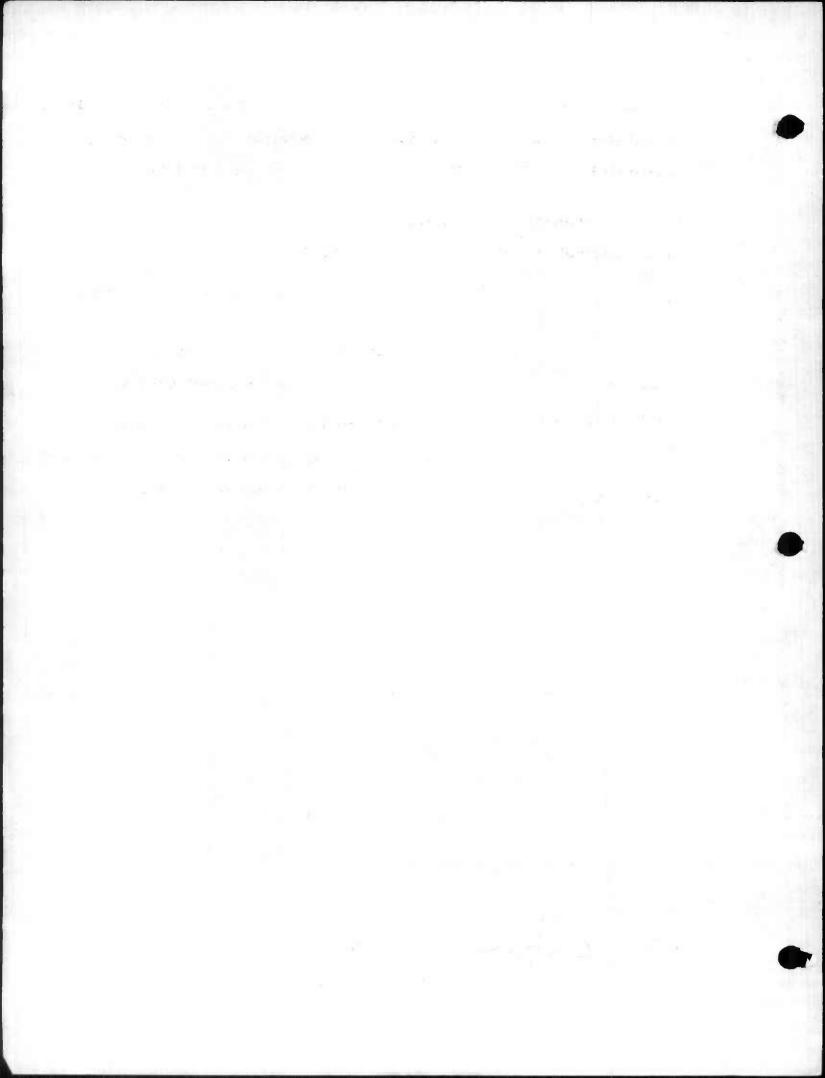
150607



epartment of r	health and Mental
Cartificata of	Dooth

							Jen	illicate	e or	Death			Reg. No.		01610
ļ	Physici /Medic		1. Decedent's Name (First, Midd Mable S									2. Date of De Month Feb 2	eath	Yeer	3. Time of Death 3:45PM
)	Examir		4e. Fecility Neme (If not institution Springhouse M			th Serv	ice				wn, or L heso	ocation of Dea		of Death	ery
	uneral rector		5. Sociel Security Number 228-72-1780	6. Sex 1 ☐ M 2/7 F		(In yrs. last birth	rs.	If Under Months	1 Yeer Days		24 Hrs. Min.	8. Dete of Bi (Month, D. April	rth Y 2 1904	9. Birth	place (Stete or Foreign
Maryland	f show	٥	Usual Residence of Decedent 10e. State 10b. County MD Mont	gomery		10c. City, Town Beth								1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the	a or 28a	Funeral Director	10e. Street and Number 5101 Ridgefie		314	20011		10f. Zip		0816	_		10g. Citizen of 1	Whet Cou	**
d 21215-0020 filed within 72 hours after death with the Manyland Hyglens.	important: if item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, tre Medical Examiner must be notified at once.	by Funera	11. Marital Status 1 □ Never Merried 2 □ Mar 3 ☑ Widowed 4 □ Divorced	ried 1 Yes	Forces? s 2 No Give			as Decede Yes, speci				pecify Yes or No Rican, etc.)	5 14. Rac Ble	ck, White,	can Indien, etc. HITE
215-C	Andical E	Completed	(Specify only highe		·		Decede 'Give ki life. Do	ent's Usue ind of work O NOT use	l Occu k done e retire	pation during mos	t of work	sing	16b. Kind of B	ualness/în	duatry
d 212 filed with Hygiene.	ther than	Comp	Elementery/Secondary (0-12) 17. Fether's Neme (First, Middle,	4-	(1-4or 5+)	Mu	sic 7	Геас		er's Nam	e (First. Middle	Music	ne)	
arylan	narked o	To Be	Joshua Selley						10:	N	lary	Elizab	eth Cris	mon	
e, Ma and 2 sl	m 27 is r her traur		19e. Informant's Name/Relations Stuart S Dye	, Son			5	004 ()ve1			Bethesd	a, MD 20	816	
Baltimore, Maryland 21215-0020 semit. Pagas 1 and 2 should be filed within 72 hours att Departmant of Haalth and Mental hygiene.	ant: if ite lury or ot		20e. Method of Disposition 1 Durial 2 Cremation 4 Donation 5 Other (S		m State	20b. Placa of I cemetery Salt	, creme	etory or of	her ple	City (Cem	3/9/98	20c. Location - Salt		City, UT
Baltimo	any in		Salt Lake City City Cem. 3/9/98 Salt Lake City City Cem. 3/9/9												22302
/Me Exa	sician edical miner	ler	23a. Part1. Enter the disease, eshock, or heart failure. Light Immediate Cause (Final disease or condition resulting in death)	only one cause or	eng	Jue to (or as a co	٠,	he	or dy	ng, such as	Lul	had a	arrest,		Approximete Interval Between Onset and Deeth
Certificate be executed	iding physician and usa as the burial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	с		ue to (or as a consequence of):									
	igned by the attendir be detached for usa	Physician/	Part II. Other significant condition	d	death but	not resulting in t	the und	derlying ce	use gi	ven in Part i			tobacco use co	/	o the cause of death?
inber /	2 should	Completed by											s an eutopay ormed?	av	ere autopsy findings allable prior to impletion of ceuse death?
Tai n	pa	0	25. Was case referred to medica	1		-				26 Place	of Tool	1 ☐	Yes 2010	1[☐ Yes 2☐ No
> 15		0	examiner?	Hospital:	7 Innettoni	2 ER/Outs	ntiont	3□ DO/	Ot	her /			idenca 8 □Oth	(C)	£.1
VISION OF VITA Attending Physician: r death.	Aftar thi funeral	-	27. Manner of Death 1 Natural 5 Pendir 2 Accident Investi	28e. Dat	te of Injury onth, Dey	28b. Tir		-	Bc. Inju				how injury occur		<i>y</i> /
or Atten	Director:	Certification:	3 Suicide 6 Could determ	not be 28e. Ple	ce of Injur Iding, etc.	y - At home, farn (Specify)	n, stree	et, fectory,					(Street end Numb wn, Stete)	er or Run	al Route Number,
- Hospita	5	edical	29a. Certifier 1 Certifyir (Check only one) 1 Medical	g Phyeician: To the Examiner: On the and me	he best of basis of e	xamination and/	deeth o	occurred a estigation,	t the ti	me, date an opinion, dea	d place, th occur	and due to the red at the time,	cause(s) and ma date and piece,	anner as a and due to	stated. the cause(s)
40	Commo	M.	29b. Signature and title of certified	2	-				-	se number	20		29d. Dete signe	/	
d			30. Name and address of person	JUSIN	use of dea	ath (Item 23a) (T	ype, Pr	rint)	u.	40	h	h Mo	2/20	P(5	

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month John 63 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death NUVSIUS 40me 0/40519 toward Lovien If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Y Oct. 20 7. Age (In yrs. last birthday) Year) 1936 Days 1**∑**M 2□ F 214-36-6782 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2☐ No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 Cedar Lane 21044 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces?unknown 1 □ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 StaNever Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) unknown unknown 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) John Duncan/son unknown 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) in state 21. Signature of Funeral Service Los Joseph B 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

The law requires that the death certificate be executed

signed by the e

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

by

Completed

2

Certification:

Medicai

Records, P.O. Box 68760.

Division of Vital

permit. Pege Depertment of Important: If any injury or

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Funeral

Director

Peges 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

erment of Health and Mental Hygiene. ortant: if Item 27 is marked other than "natural", or thems 23s or 28s-f show injury or other traumatic event, the Modical Examination until be notified

Examiner physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Last Physician/Medical for use as t

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical 1 Yes

27. Menner of Death 1 Natural

2 Accident 3 Suicide 4 Homlcide

29a. Certifier

5 Pending investigation

6 Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certific

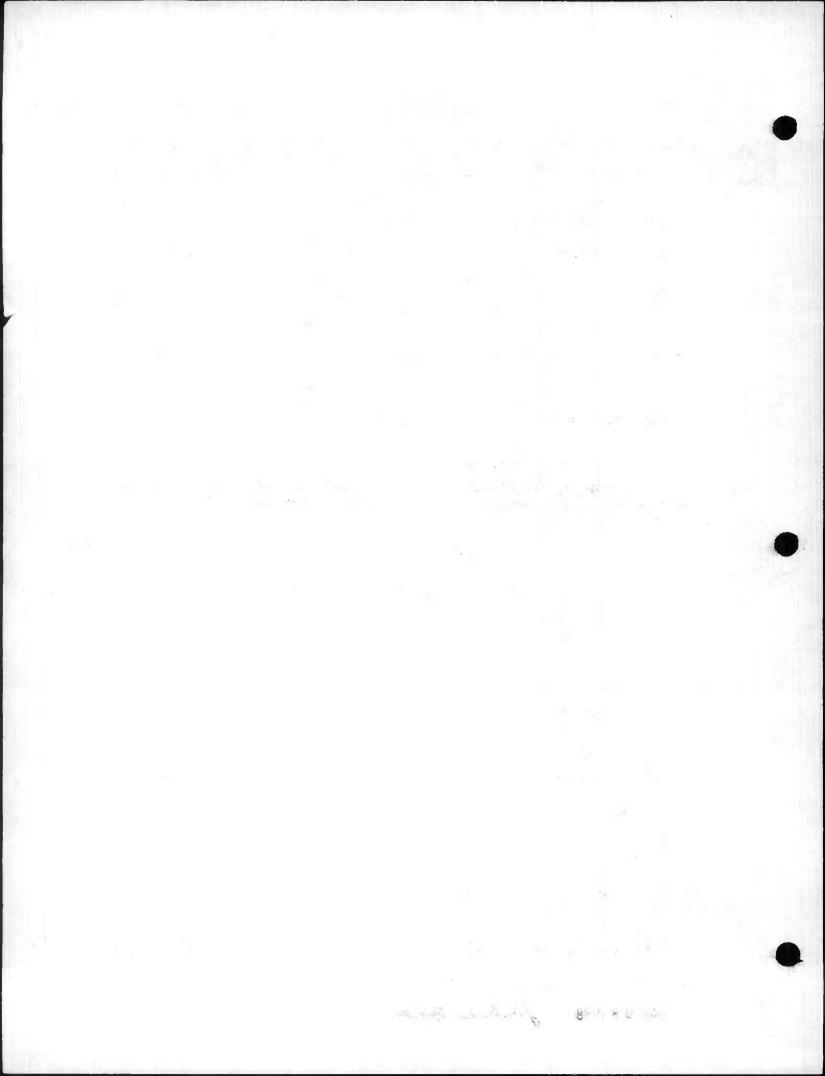
28c. Injury at Work?

29d. Date signed (Month, Day, Year)

30. Name end address of person pleted cause of death (Item 23a) (Type, Print) bary K92/00/08 4ickory Rigge Rd Columbia, Mg 21044

31. Date filed (Month, Day, Year)

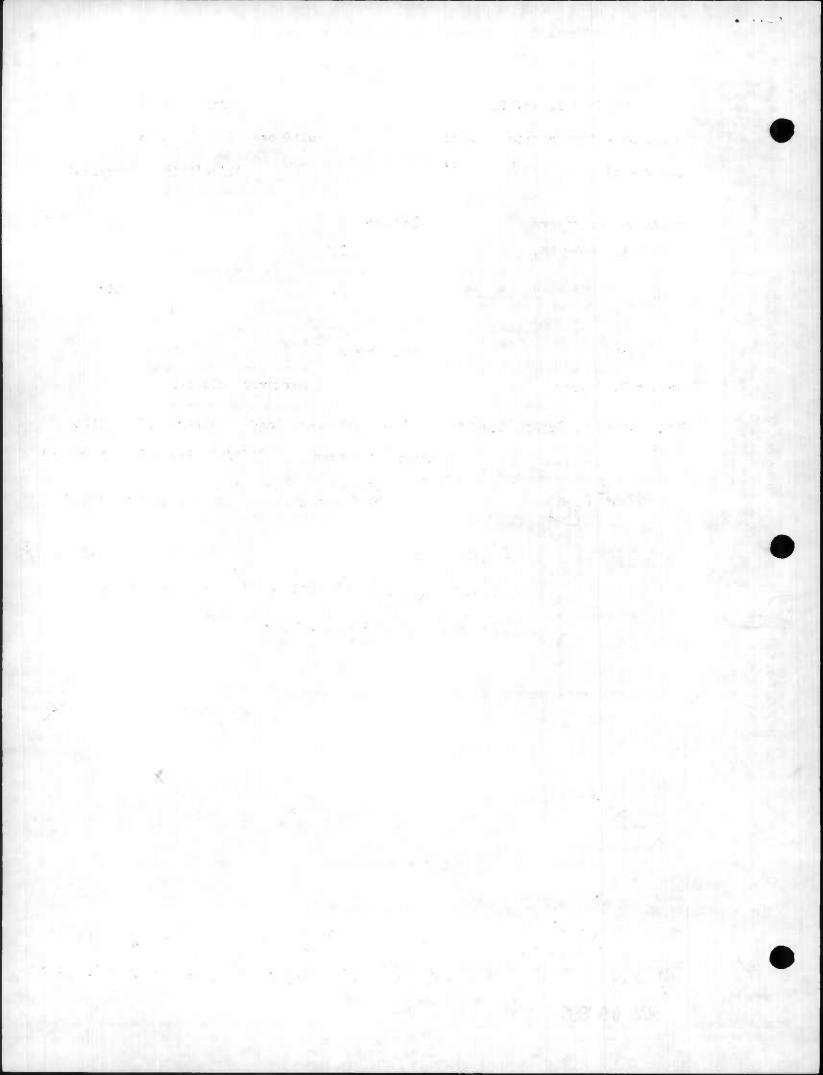
State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

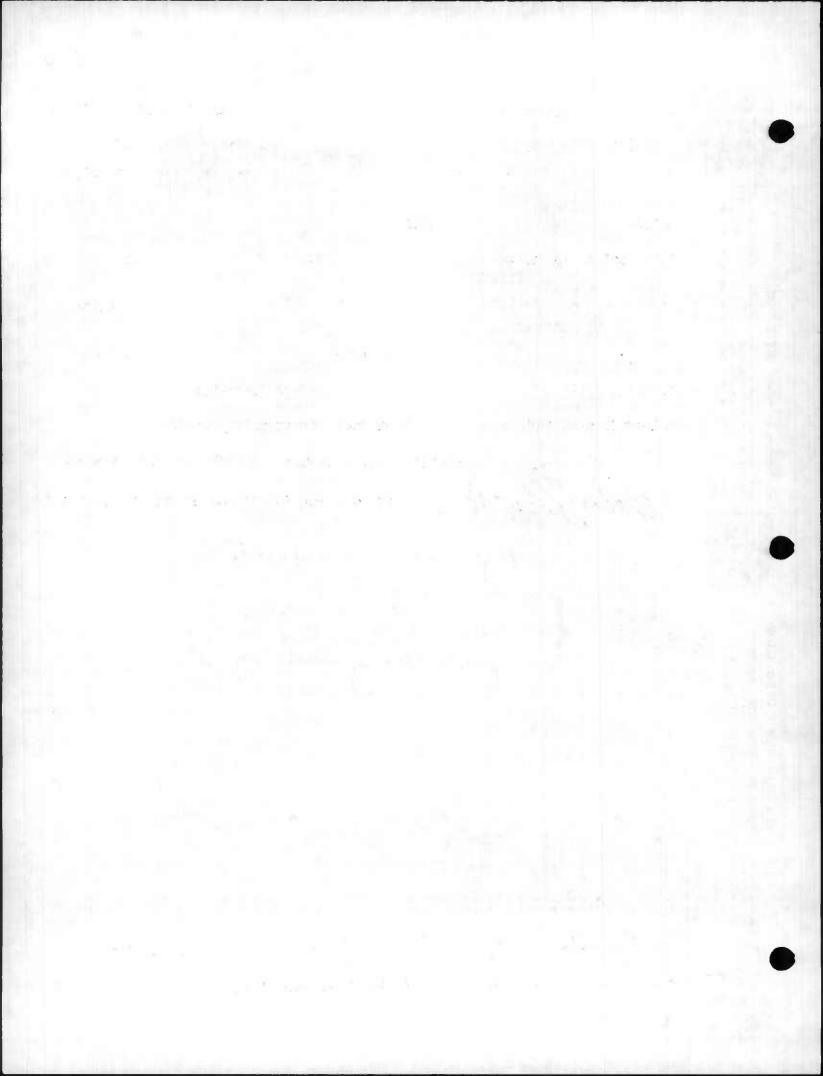
State of Maryland / Department of Health and Mental Hygiene 0 07075

	1. Decedant's Nama (First, Mid						2. Date of De Month March	oth Day 998	Yeer	3. Time of Death
/Medical	MILGT ed 4a Fecility Neme (If not institut	S. Erski				4b. City, Town, o	March Location of Deet		of Death	
Examiner	Good Samarita					Baltimor		N/A		
Funeral Director	5. Sociel Sacurity Number 214-01-8114	6. Sax 1 □ M 2X	7. Age (In yrs 83	. last birthday) Yrs.	If Under 1 Year Months Day			th y, Yaer) 1915	9. Birthpl Count Mary	ace (Stata or Foreign (ry) Land
M #	Usual Rasidance of Dacedant 10a. Stata 10b. Cour		10c. C	ity, Town or Lo	cation				10	0d. Insida City Limits
or 28a-f show a notified at Director	Maryland Balt	imore		Carr	ney					1 ☐ Yas XX No
23a	10e. Street and Number 3129 Willoughb	y Rd.			10f. Zip Code 21234			10g. Citizen of V USA	What Count	try?
Important: If flam 27 is marked other than "natural", or itsma 23a or 28a-f sho any lojury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 ☐ Navar Marriad 2 ☐ M	larried 1 TY	Decedant Ever in I d Forcas? es 2011No , Give or Datas:		Was Decedant of f Yes, specity Cu 1 ☐ Yes 2 ☐ N	f Hispanic Origin? (uban, Maxicen, Pue o <i>Specify:</i>	Specify Yes or No rto Ricen, atc.)	- 14. Rac Blac Specify	e - Americe ek, Whita, e White	etc.
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To B	Robert I. Snyd	ler				Margar	et McPol	and		
ls me	19a. Informant's Name/Relation					et and Number or F				
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Importar any injui	21. Signatura of Funaral Sarvi		k T. Zav	oyna 22		Trass of Facility J. Ruck		mono M	4 2	1214
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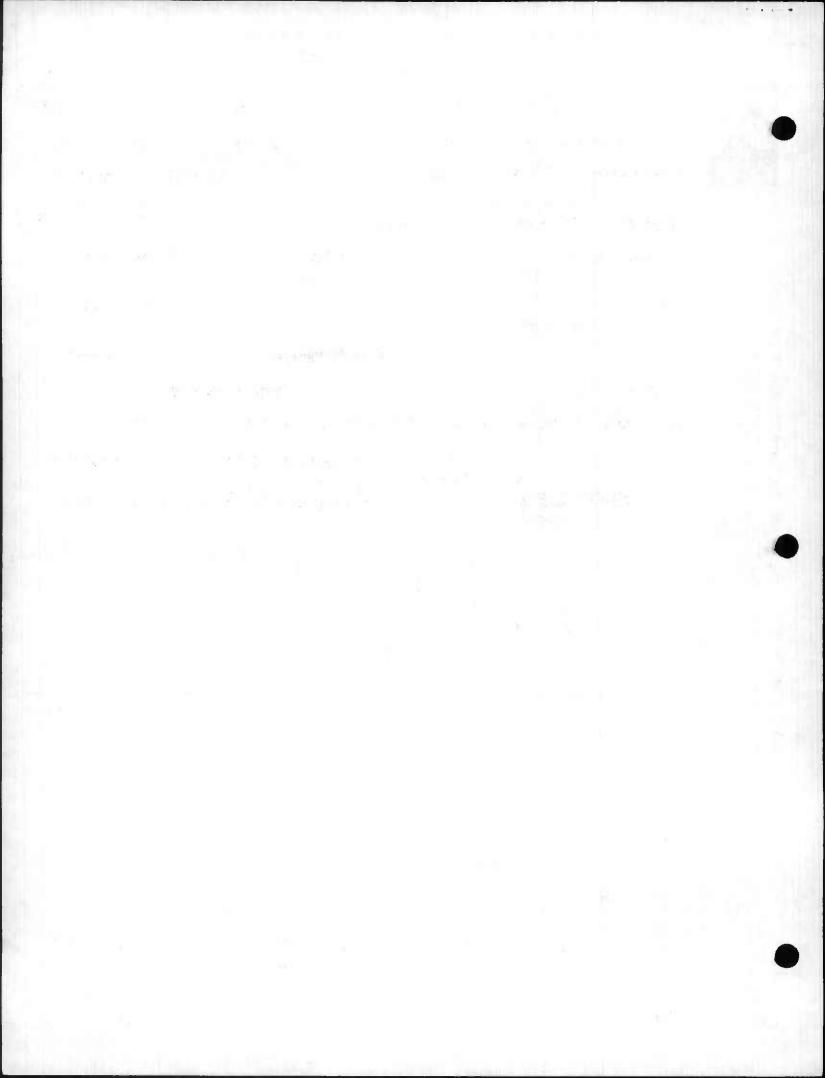
	1. Decedent's Name	/First Middle Las	(t)		Cer	tificate	of	Death		2. Date of De	Reg. No.	107	3. Time of Death
Physician /Medical		e Elizabe	eth Ferr				- 1	4b. City, Tow		Month March eation of Deat		Year 8 unty of Dea	11:44 PM
Examiner Funeral Director	Good Sam 5. Social Security No. 212-18-0	aritan Ho umber 6. S 206	spital		lest birthday) Yrs.	If Under 1 Months			Balt 4 Hrs.	imore 8. Date of Bir (Month, Die	rth	n/a	
8 m	Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Loc	cation							10d. Inside City Limit
artsh otor	Maryland	n/a/	/		Baltimore	9							1 Yes 2□N
or 28a-f s be notified Director	10e. Street and Nun					10f. Zip C					10g. Citizen	of What C	ountry?
r items 23a piner must Funeral	2807 Mon	tebello 1	12. Was Decede	ent Ever in I	IS 13 V	Ves Decede		21214 Hispanic Origi	in? (Sne	cify Yes or No	D- 14.	USA Rece - Am	erican Indian,
by by	1 ☐ Never Marrie 3 ☐ Widowed		Armed Force 1 Yes 2 If Yes, Give Year or Date	es? □ X No	If	Yes, specif	fy Cuba	an, Mexican, Specify:	Puerto F	lican, etc.)		Black, Whi	
than 'natur to Medical mpleted	Elementary/Secon	15. Decedent's Ed ify only highest gre- ndary (0-12)	de completed) Cotlege (1-4	or 5+)	life. L	ent's Usual kind of work OO NOT use OMEMAK	retired	oation during most o d)	of workin	99	16b. Kind	of Business	
arked other atic event, to To Be Co	17. Fether's Name (First, Middle, Last)			1110	Jiiciian	(0)	18. Mother	's Name	(First, Middle	, Maiden Su		ionic
ToB	Nicholas	Failla						Rosa	Cam	aratta			
T is m treum	19a. Informant's Na			ha I I i						Route Numb		own, Stete,	Zip Code)
Item 27 other tr	Mr. Louis C 20e. Method of Disp		(Nepriew)	20b.	4 Erwoo	sition (Nem	e of		re, r	Maryland Date		ion - City o	Town, Stete
Important: If Is any Injury or once.	1 X Burial 2 Donation	Cremation 3 5	Removal from St	ate	cemetery, crem t Holy Re				3/7	7/1998	Baltim	ore M	aryland
	21. Signature of Fundamental States of Part . Enter the shock, or hear	ne disease, or complete trailure Last only	Such	sed the dea th line.	Lec	onard J	. Ru		. 530			Balto	o. Md. 21214 Approximate Intervat Between Onset end Death
edical aminer	Immediate Cause (I disease or condition resulting in death)	Final	a May	O Ca	or as a conseq	uence of):	71	ıfa	nel	Tion			
attending physician and for usa as the bunal-transit clan/Medical Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	njury	b. 180 c. D.	ene	or as a consequence or es e consequence of the cons	a	70	edi	ing) 1	ulre		
ached ached hysic	Part II. Other signifi	cant conditiona co	ontributing to deat	h but not res	sulting in the un	nderlying ca	use giv	ven in Part I.			Yes 2		a to the cause of deat Probably 4 Unknown
page 2 should be det										24a. Wa peri	s an autopsy ormed?	24b.	Were autopsy findings available prior to completion of cause of desth?
Corr										1□	Yes 200	No	1 ☐ Yes 2 No
this certificate he al director, page To Be Com	25. Was case referrexaminer?		Hospital:		3 FD/O-4		Oth	oer.		(Check only		7011 (0-	a alfait
r: After this one funeral direction: To	27. Manner of Death 1 Maturat 2 Accident	5 Pending			28b. Time of Injury		c. Injur Wor	4 PATRUE	2	ne 5□ Res 8d. Describe			eciry)
To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Suicide 4 Homicide	6 Could not be determined	building	, etc. (Speci			4			City or To	wn, Stete)		Rural Route Number,
Fune etely f	29a. Certifier (Check only one)	1 Cartifying Phy 2 Medical Exam	ysician: To the be linar: On the basi and menne	s of examina	owledge, death ation and/or Inv	occurred at restigation, I	t the tir In my o	me, date and opinion, death	placa, a n occurre	nd due to the ed at the time	cause(s) an , date end pla	d manner a ace, and du	is stated. ie to the cause(s)
omple Me	29b. Signature and	title of certifier	Trip	كسا	eni	29c.		306	61				nth, Day, Year)
			V			-					March 6	, 1998	



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State of Maryland / Department of Health and Mental Hygiene

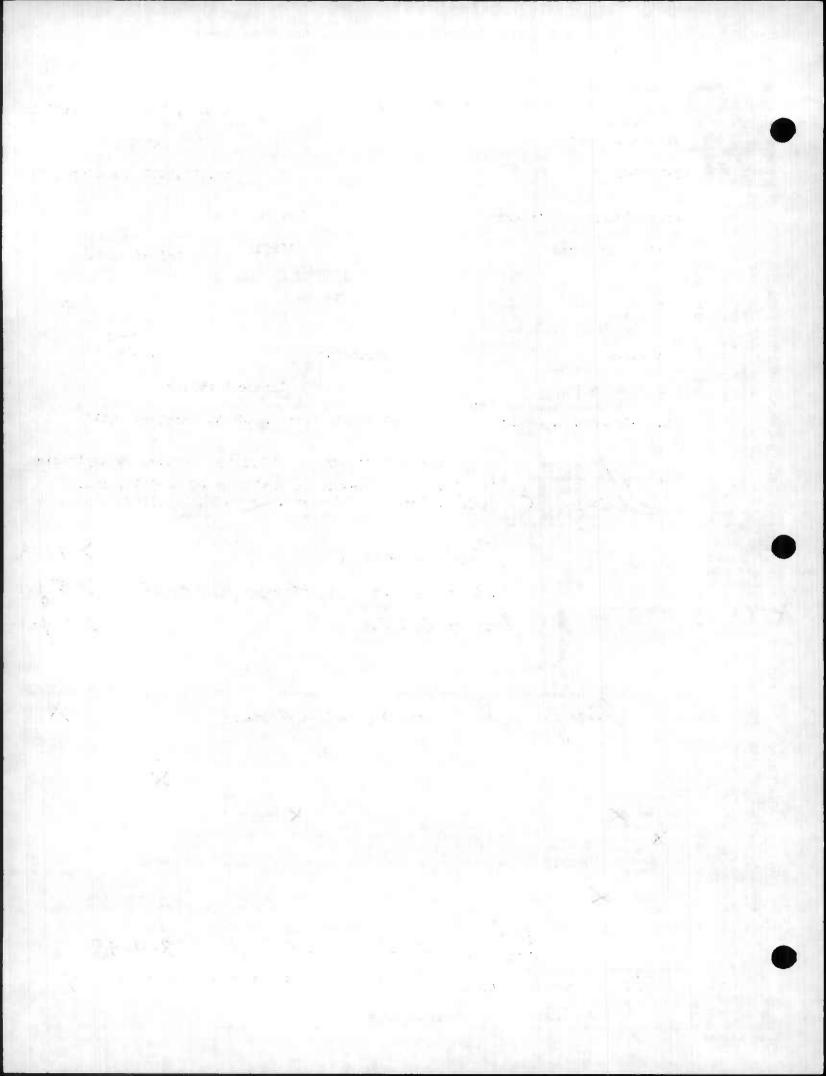
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ŀ			The Good Saman 5. Social Security Number 6. S		(In yrs. last t	hirth day)	If Under 1	Vear	Baltin If Under 24 Hrs		and the	N,	/A	(0)	- 6. 17.
L	Funeral Director			1 M 2 M F 7. Age	86			Deys	Hours Min		ay, Year	1		ece (State try) ryland	
	and in		10a. State 10b. County		10c. City, To	wn or Loca	ation					_	10	Od. Inside C	City Limits
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	h with	a D	18 Maxa Court					2122	0		U	ni ted	d Sta	tes	
	Heme 2	Funeral Director	11. Meritel Status	12. Was Decedent E Armed Forces?	ver in U,S.	13. W	as Decede	nt of His	penic Origin? (Specify Yes or N to Rican, etc.)		14. Race	e - America	an Indien,	
21215-0020	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show solical Examiner must be notified at	þ	1 Never Merried 2 Married 3 Nover Merried 2 Noverced	1 Yes 2 No			Yes 2		Specify:	to nican, etc.)		Specify	k, Whife, e	ite	
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Mar	le sho and is me raum		19e. Informant's Neme/Reletionship (ural Routa Numi				Coda)	
	s 1 and 2 should be filed within f Health and Mental Hygiene. tem 27 is marked other than other traumatic event, tre M		Mrs. Carolyn M. Bi 20a. Mathod of Disposition	runner / NIG			xa Co			imore, M		2122		0	
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tim	t. Pa timer tant:		4 □ Donetion 5 □ Other (Special				dral			3/7/98	Ba	ltim	ore,M	laryla	nd
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	and trans	Cam	Sequentially list conditions,	0.	ue to (or es	е сопъеди	ence of):				n				
90,	oe ex		Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disaasa or Injury	erar	nolo	ny	10	0 0	Buch	dura	1.				
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Box	eeth cer ettendir for use	lan													
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<u>S</u>	after Dire d in t	ert	4 ☐ Homicida	building, afc.	(Specify)		, , ,			City or To					
	To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifiar 1 Certifying Ph	ysician: To the bast of	my knowledg	ge, deeth o	occurred et	tha tima	, data and place	e, and due to the	cause(s) end me	nner as ste	eted.	
	he Ho in 24 he Fu plete	edical	(Check only 2 Medical Examone)	niner: On the besis of e end manner stet	exemination e	end/or Inva	stigation, Ir	n my opir	nion, death occ	urred et tha time	, dete er	nd plece, e	and dua to	the ceusa(s)
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			Much	loup			-	V 3	50001		Ma	nen	H	, 7	0
	1		30. Neme end eddrass of person who	completed causa of da	eth (Itam 23e) (Type, P	rint) S	IRE	ESH	KITR	LIP	URF	NE	101	
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	Sta		31. Date filed (Month, Day, Year)	Julia Burista	s Spanna	22						-			



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State of Maryland / Department of Health and Mental Hygiene

				Certificate of	or Death		Reg. No.	01210							
	1. Decedent's Neme (First, Middle, L		OVE HIS			2. Dete of Month	Deeth Dey	3. Time of Deel							
cian Iical		Pauline Cat	herine G	avis		March		1:35 7							
ner	4e Fecility Neme (If not institution, g	ive street and number)			4b. City, Tow	m, or Location of De	eth 4c. County	of Deeth							
	Riverview Nursin	g Home			Es	sex	Balt	imore							
	5. Sociel Security Number 6. 197–24–1862		(In yrs. last birtho	Months De		4 Hrs. 8. Dete of (Month,	Birth Day, Year) 11,1907	9. Birthplece (State or Fore Country) Hazelton, Pi							
	Usual Residence of Decedent														
	10a. Stete 10b. County		10c. City, Town o	r Location				10d. Inside City Lin							
ior	Pennsylvania	Luzerne			West	Hazelton		1 ☐ Yes 2🖔							
I Director	10a. Street and Number 238 North Stree	t		10f. Zip Coo		201	10g. Citizen of Whet Country? United States								
Funeral	11. Maritel Status 1 ☐ Never Married 2 ☐ Merried	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No	ver In U,S.	13. Wes Decadent If Yes, specify (of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No- 14. Reci Blac	a - American Indien, sk, White, etc.							
2	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:		1□ Yes 2□	No Specify:		Specify	White							
	15. Decedent's I	Education	16e. De	ecedent's Usuai Oc	cupation		16b. Kind of Bu	usiness/Industry							
Completed	(Specify only highest g	rede completed)	(G	Give kind of work do	one during most (tired)	of working	1	Bank							
E O	Elementery/Secondary (0-12) 4 Years	College (1-4or 5+	-)	Custodi	an			itorial							
	17. Fether's Neme (First, Middle, Las	st)			18. Mother	's Neme (First, Mid	dle, Maiden Sumem	10)							
o Be	Andrew Podlesn	v			E1:	izabeth M	ylath								
Ĕ	19a. Informent's Neme/Reletionship		19h M	feiling Address (St			mber, City or Town,	State, Zip Code)							
	Mr. Salvadore A.	(-)/					Maryland								
		04.125													
		Removei from State													
	4 Donetion 5 Other (Spec	cify)	Calvary					Pennsylvania							
edical Examiner	disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	. Dre	rona	negatince of):	21. Signature of Fureral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundal 7922 Wise Ave. Dundalk, Marylar 23a. Part. Enter the discrete, or combications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
-	resulting in deeth) Lest	d						739							
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by Physician/M			not resulting in the \mathcal{VO}		1 1	18/ase 1		3 Probably 4 Unkers 24b. Were autopsy finding available prior to completion of cause							
by Physician/M			not resulting in the	ne underlying ceuse	1 1	Slase 1 240. V	Yes 2 No	3 Probably 4 Unker 24b. Were eutopsy finding available prior to completion of cause of death?							
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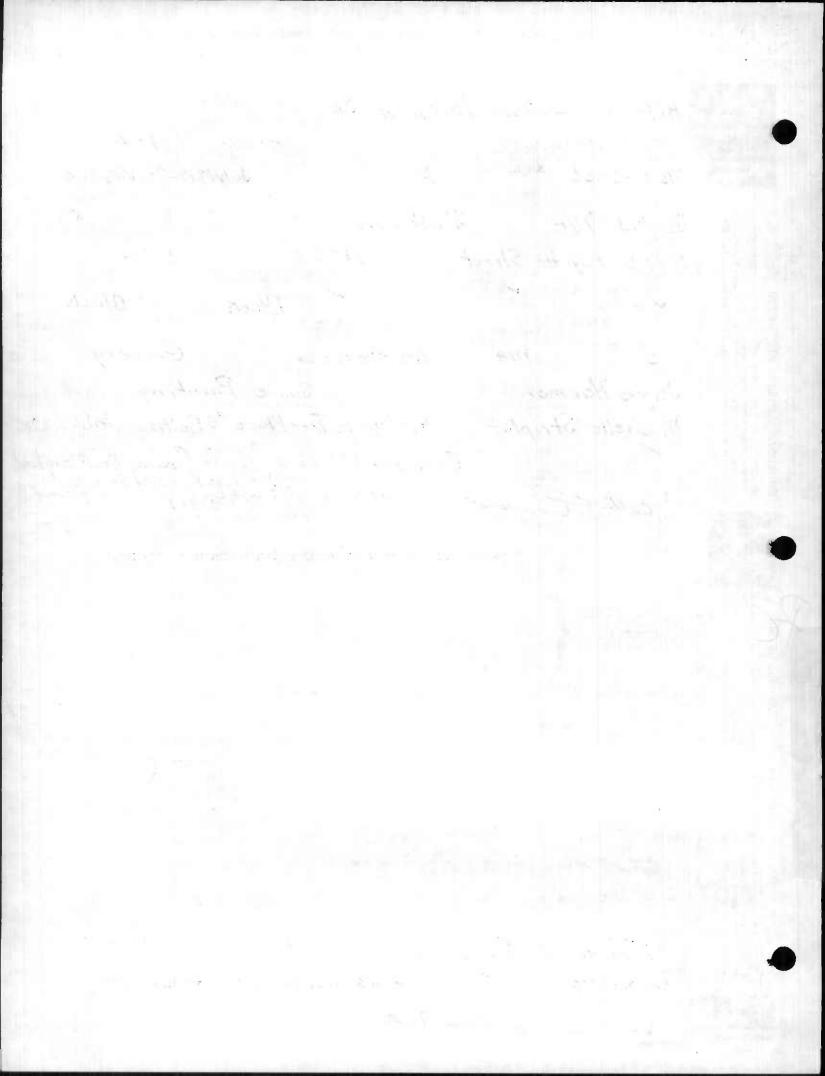


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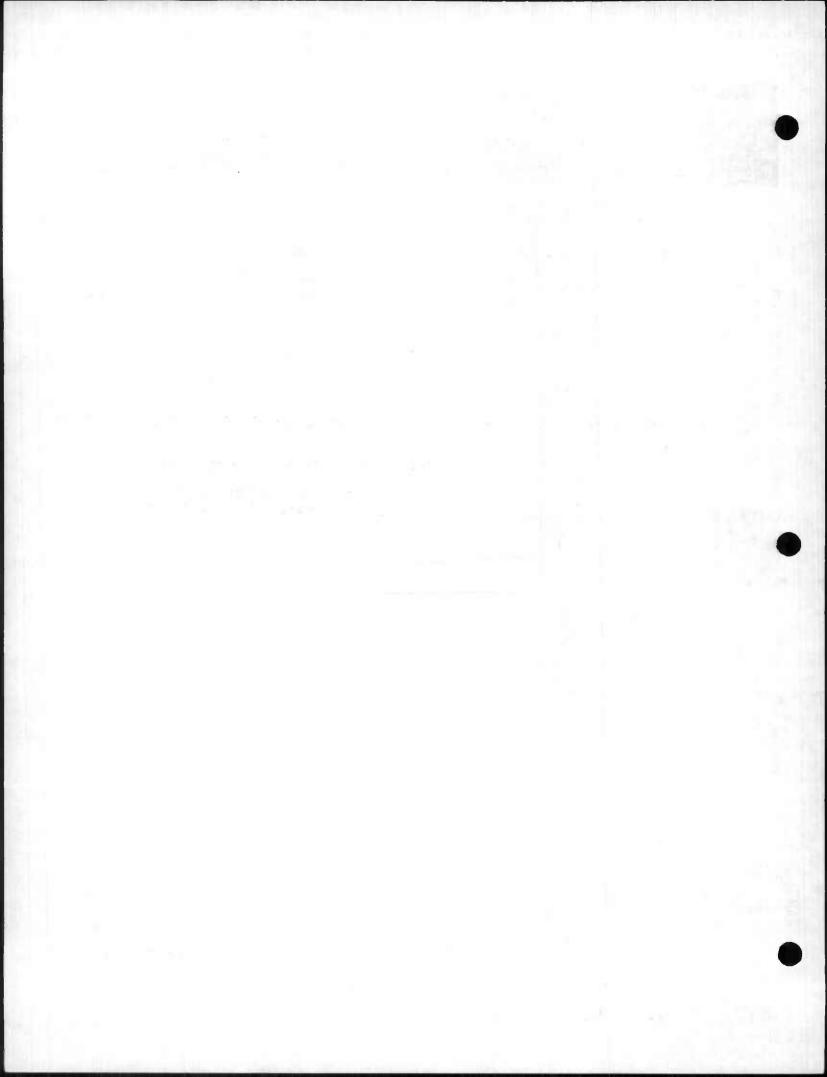
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Examiner	4a Facility Name (If not institution,		er)			4b. City, Town, or	Location of Death	4c. County	of Deeth	
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Funeral Director	5. Social Security Number 212-12-02-6 Usual Residence of Decedent	5. Sex 1 M 2 □ F	Age (In yrs.	75 Yrs. Mont		ays Hours Min.	8. Date of Bir (Month, De	1922 1922	1 /	(Stete or Foreign
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28s-f shownout and street or rector	Markoul n/A	9	B	altimor	P				1	Yes 2□No
or 284	10e. Street and Number	Ga. Letter		10f.	Zip Co	de		10g. Citizen of	Whet Country?	
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fiver must be notified.	11. Meritai Status	12. Was Decede		I,S. 13. Was Do	specify	of Hispenic Origin? (S Cuben, Mexican, Puer	specify Yes or No to Rican, etc.)	- 14. Rac	ce - American In	idian,
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alon alon	Eiementary/Secondary (0-12)	College (1-4	or 5+)	1 1 1		one during most of wo etired)		1		
Ö	6	nia		Wareh	0450	man	(Fi) 14 date	Gro	cery	
8	17. Father's Neme (First, Middle, L	ast)				18. Mothers Na	me (First, Middle,	, Maiden Sumei	me) /	
٥		non				Susie	DUT	nting		
To Be C	19a. Informent's Name/Relationsh	p (Type, Print)		19b. Mailing Add	ress (Si	- 01	urel Route Numb	er, City or Town	, Stere, Zip Coo) 2/24
or other	20a. Method of Disposition	riplet	20b.	Place of Disposition	Neme o	of	ce B L	30. Location	- City or Town,	1-21-228 State
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Injury	4 Donetion 5 Other (Sp.		Cro	wnsville	Ve	terans	13,1998	Crowns	suille, 1	Jary lan
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rector, page	25. Was case referred to medical					28 Place of Do	ath (Check only		10.0	3 2 140
director, pay	examiner?	Hospitei:	estiont 2	ER/Outpetient 3	l DOA	Othor	Home 5 X Resi		her (Specify)	
	27. Manner of Death	28a. Date of (Month,		28b. Time of		Injury et Work?	Y	how injury occu		
e fun	1 Naturei 5 Pending 2 Accident investiga		Dey Year)	Injury M		Work? 1 ☐ Yes 2 ☐ No				
in by m	3 Suicide 6 Could not determine	Zee. Piece of	Injury - At h , etc. (Speci	nome, ferm, street, fe	ctory, of	fice		(Street and Num wn, State)	ber or Rural Ro	ute Number,
completely filled in by the funere	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminar: On the basi end manner	s of examina	owledge, deeth occur ation end/or investiga	red at the	he time, dete and piec my opinion, deeth occ	e, end due to the urred et the time,	ceuse(s) end m dete and plece	nenner as stated , end due to the	i. cause(s)
Me Me	29b. Signature and title of certifier	GIIG (IIIIIIIII)	Junea.		29c. Li	cense number		29d. Date sign	ed (Month, Dey,	Yeer)
8	1//	111.				O.C.M.E.		MARCH 0		
	/ perlon	21./479) ms							
-1	30. Name and address of person we Theodore King M				C+~	eet, Baltir	nom Ma	bacland	21201	
					o LLE	ser, partil	iore, Ma	тАтапи	21201	
State	31. Date filed (Month, Day, Year)	32. Heg	istrer's Sign	eture						



Items: 23a Part Iab,29a Per MD Film G-757 3-9-98RC

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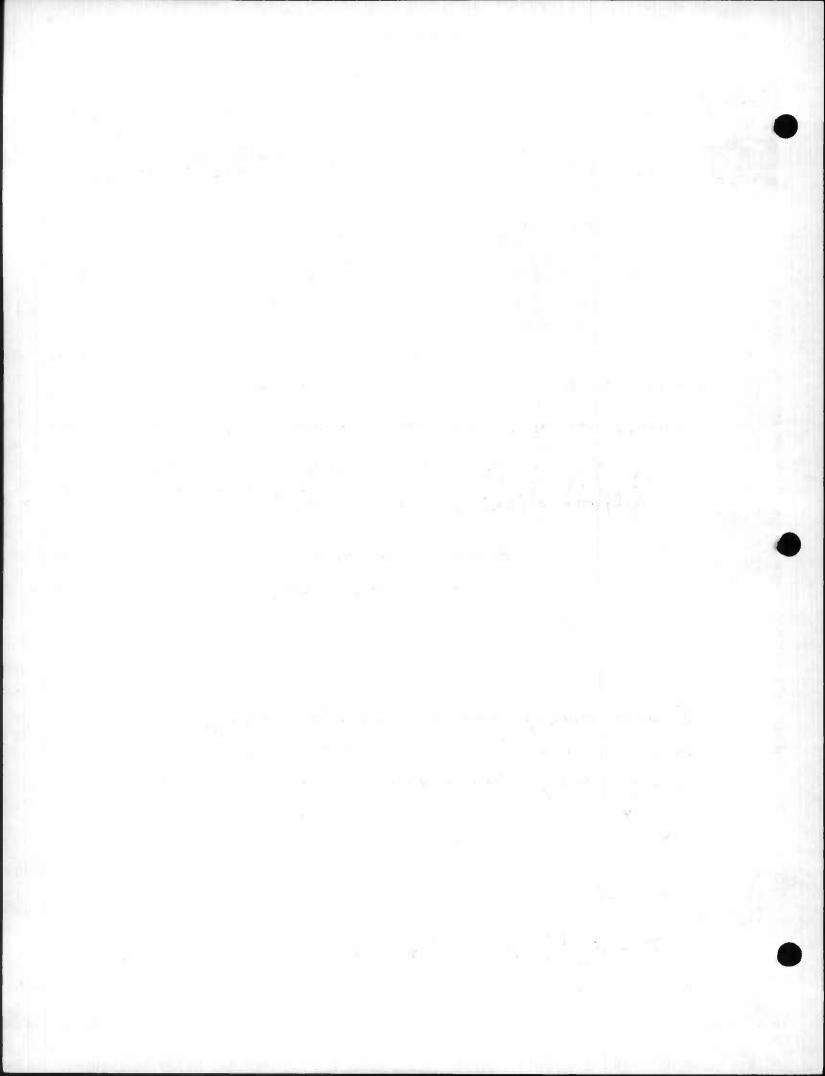
Physici		1. Decedent's Nem	ne (First. Mide	dle, Last)					of L		2. Dete of De	Reg. No. eth	3.1	Time of Death
/Medic	:al	Burley	1 4	chs						D. Ch. Taura	FeBruar	Dey Ny 26	1998 1	3 pm
Examin	er	4e. Facility Neme (Agnes						4	b. City, Town, or L Baltir		4c. Coun	n/a	,
uneral rector		5. Sociel Security N 087-10-3	Number 618	6. Sex		. Age (In yrs.		If Under 1 Months I	Year Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Da June 1	, 1914		State or Foreign
M til		Usual Residence of 10a. Stete	10b. Count	ly		10c. Cit	y, Town or Loc	cation					10d. In	side City Limits
zea- show	ctor	Md.	Bal	timor	^e			Mid	dle	River			11	☐ Yes 2 🕅 No
other traumetic event, the Madical Extender rotal be notified at	rai Director	10e. Street end Nu 2110 C		orn f	Road			10f. Zip C		1220		10g. Citizen of USA	What Country?	
- Mandager III	by Funerai	11. Marital Status 1 Never Marital Status 3 Widowed		rried	Armed Ford 1 Yes 2 If Yes, Give Yeer or Det	. □¥No		Ves Deceder Yes, specify		ispenic Orlgln? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)	Spec	ace - American Indeck, White, etc. ity: Whit	
e Medical	Completed	Elementery/Seco	15. Decede cify only high ondery (0-12)	est grede d	tion com <i>pleted)</i> College (1-	for 5+)	(Give I life. D	O NOT use	done d retired	turing most of work)	king		Business/Industry	
mr, m		9th 17. Fether's Neme	(First, Middle	, Last)			Fork	lift	0pe	rator 18. Mother's Nem	e (First, Middle,		,	er y
raumatic event, the M	To Be	Edwa	rd Hic	ks						Li	llie Sh	afer	0.	
raume		19a. Informent's N								and Number or Ru				*
or other		Doroth 20e. Method of Dis 1 Durial 2	position			20b. P	Pleca of Disposemetery, cram	ition (Name	of		Road B		e MD. 21	
dury		4 Donetion	5 Other (Specify)			elAir M	lemori	al	Gardens	3/2/98	BelA	ir Md.	
any injury once.		21. Signeture of Fi	unerei Service	a Licensee	0	1	1. 22.	Conne		Funeral	Home o	f Essex	(
	Н	23a. Perti. Enter t	the disease, cart feilure. Lis	or complica	Hons thet ca	used the deat	h. Dolnstente						221 Appr	oximete vel Between
ical in ical incartual ical incartual ical ical ical ical ical ical ical ic	an/Medical Examiner	Immediate Ceuse disease or condition resulting in deeth) Sequentielly list or if eny, leeding to incause. Enter Unde Ceuse (Disease or that initiated event resulting in death)	onditions, mmediete erlying rhjury	e. d. d. d. d. d. d. d. d. d. d. d. d. d.	Head	Due to (o	r es e conseque	uence of):ACU uence of):		VE HEART		E	IO Un	years known
ē	Physician/M	Pert II. Other signif	ficant conditi	lons contri	buting to dea	th but not res	ulting in the un	derlying cau	se giv	en in Pert I.	23b. Did	tobacco uee c	ontribute to the	ause of death?
peu											10	Yes 2 No	3 Probably	4 Unknown
e detached												en eutopsy	24b. Were au	tonsy findings
2 should be d	þ											emed?		prior to on of cause
page z snouid be d	þ											omed?	complet	prior to on of cause ?
page 2 should be d	Be Completed by	25. Wes case reference exeminer?			snitel: 2/				Othe	26. Plece of Dee	perfo	Yes 2X No	completion deeth	prior to on of cause ?
ral director, page 2 should be d	To Be Completed by	exeminer?	No		28a. Dete of	Injury	ER/Outpetient		Other.	er: 4 Nursing H	perfo	Yes 2X No	complet of deeth	prior to on of cause ?
Juector: Arier rins certificate has been signed in by the funeral director, page 2 should be d	To Be Completed by	exeminer?	th 5 Pendi Invest	Ho-	28a. Dete of (Month)	Injury Day Year)	28b. Time of Injury	М 280	Injun Worl	er: 4 Nursing H	th (Check only of ome 5 Resi	Yes 25 No one) dence 8 0 how Injury occurs	complet of deeth	a prior to oon of cause ?
Director: After this certificate has been signed in by the funeral director, page 2 should be d	Certification: To Be Completed by	exeminer? 1 Yes 2 27. Manner of Deet 1 Neturel 2 Accident 3 Suicide	th 5 Pendi Invest 6 Could deten	ing tigation I not be mined	28a. Dete of (Month) 28e. Pleca of building	Injury Day Year) Injury - At ho, etc. (Specification of my knowledge)	28b. Time of Injury ome, farm, stre	M 280	. Injun Work 1 []	er: 4 Nursing He	th (Check only of the Check only only only only only only only only	Yes 21 No one) dence 8 0 how Injury occi Street and Nun	complet of deeth 1 Yes ther (Specify) urred	a prior to con of cause ? 200 No
vier this certificate has been signer uneral director, page 2 should be d	To Be Completed by	exeminer? 1 Yes 2 27. Manner of Deet 1 Neturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only	th 5 Pendi Invest 6 Could deten	ing tigation of not be mined ing Physic t Examine	28a. Dete of (Month) 28e. Pleca of building lian: To the ber: On the bas	Injury Day Year) Injury - At ho, etc. (Specification of my knowledge)	28b. Time of Injury ome, farm, stre	M 280 M occurred et estigetion, in	i. Injury World 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	er: 4 □ Nursing H / et k? Yes 2 □ No	th (Check only of the Check only only only only only only only only	Yes 21 No one) dence 8 00 how Injury occus Street and Num wm, State) ceuse(s) and r dete end plece	complet of deeth 1 Yes ther (Specify) urred	a prior to oon of cause? 200 No te Number,



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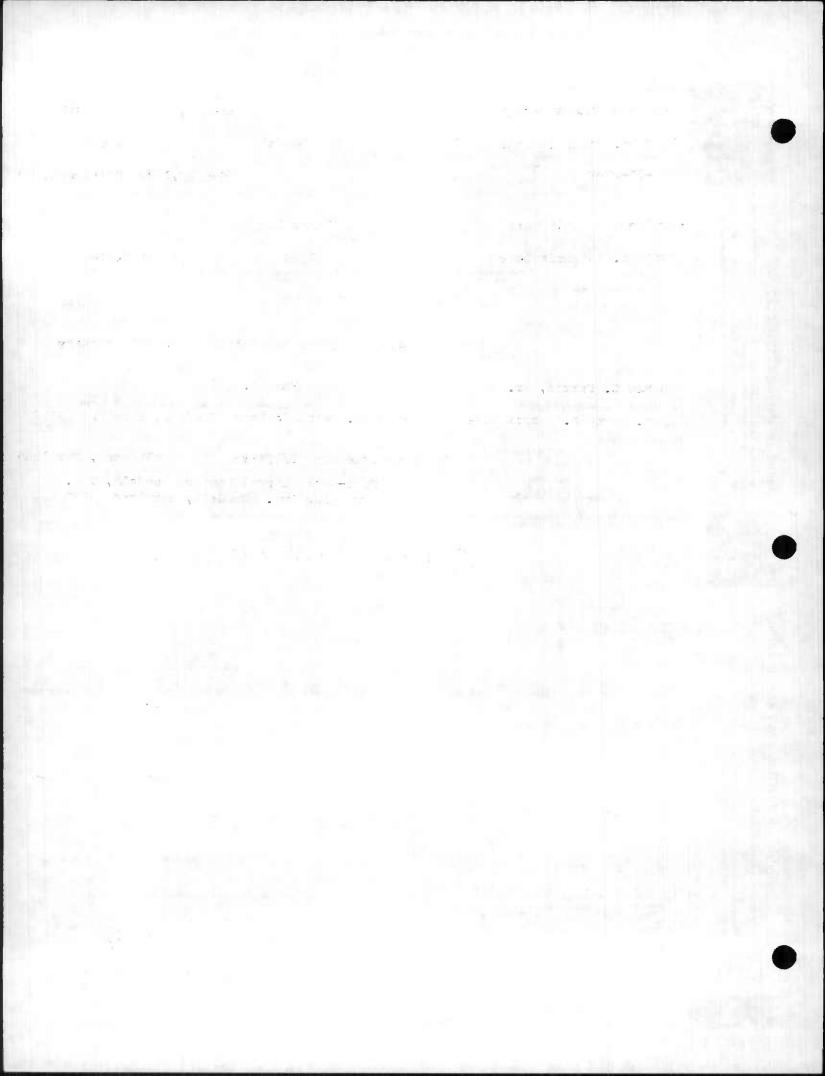
State of Maryland / Department of Health and Mental Hygiene

					,	Cei	rtificate of	f Death	Remaining	eg. No.		
	Dhusia	la-	1. Dacadant's Nama (First, Middla, Li	ast)					2. Data of Deat Month	h	Year	3. Tima of Deeth
J	Physic /Medi		Gerardo	Hermid	la					Day 1 9		3:15pm
	Exami		4a. Fecility Name (If not institution, gir	va street and number)				4b. City, Town, or L	ocation of Death			3. 13pm
L			St. Agnes Nur					Ellico	tt City	Howa	rd	
	Funeral Director		266-25-6259	Sex 7. Ag 1 □ M 2 □ F	ge (In yrs. lest i	Yrs.	If Undar 1 Yea Months Days		8. Data of Birth (Month, Day, Dec. 2	^{Year)} 5,1911	9. Birthp Coun C	placa (Stata or Foreign http:) uba
	pue M.		Usual Rasidance of Decedant 10a. Siela 10b. County		10c. City, To	wn or Lo	cation					I Od. Insida City Limits
	Mery	ō	Maryland Balt:	imore	Arbu	tue					,	1 ☐ Yas 2 🖫 No
	1 the	20	10e. Street and Number	rmore	ALDU	cus	10f. Zip Coda		10	0g. Citizan of W	Vhat Coun	ntry?
	3e of		5536 Selma Ave	aniio			2122					
	death	Funeral Directo	11. Merilal Stalus	12. Was Decedant		13. V		Hispanic Origin? (Sp ban, Maxican, Puerto	pecify Yes or No-	United 14. Race	- Amaric	can Indian.
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Meryland I Health and Mertel Hygiene. Item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Medical Experient must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorcad	Armed Forcas? 1 ☐ Yes 2 ☐ If Yas, Give Yaar or Datas:				Specify: Cul			k, Whita, Whita	
5-0	72 ho natur	ed	15. Dacedant's E (Specify only highast gr	ducation	16	ia. Deced	ient's Usual Occu	upation	kina	16b. Kind of Bu	siness/înc	dustry
21	within ene.	Completed	Elamentery/Secondary (0-12)	Collage (1-4or !	5+)	life. L	OO NOT usa retir	a during most of work ed)	ang			
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Ž	2 should be f and Mentel I is marked of raumatic eve	P P	Manuel Hermida						des San			
Ma	d 2 st th and 7 is n traur		19e. Informant's Name/Relationship					et and Number or Rui				·
	es 1 end of Health f Itam 27 r other tr		Esteher Fernac	lez, daugh	iter 5	53.6	Selma sition (Nama of	Avenue A	rbutus	Mary	land	d 21227
altimore,			1 Burial 2 Cremation 3	Ramoval from State	Corne	ary, oran	dient of other pr	ace				
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Ba	permit. Page Department of Important: If eny Injury or once.										7/ >	chutuc
_			23a. Pert1. Enter tha disease, or com shock, or haart failure. List only	> MUDU	ell -	13	328 Sul	phur Spr	ing Ro	ad Ma	ryla	rbutus and 21227
П		Н	shock, or haart failure. List only	ona cause on aech li	d the Daath. Di na.	o not ante	er the moda of dy	/Ing, such as cardiec	or raspiratory erre	est,		Approximeta Intervel Batwaan Onsat and Death
	Physician /Medicai		Immediata Ceusa (Final								Ť	
	Examiner		disaasa or condition resulting in daeth)	a. 56	PATIC) hoc	10			4	7 days.
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	ufed d	Examiner	Conventially list and dittant	b. K19	Dua to (or as	CODECO	yence of):	-eec pr	resmi	DITIE	- 1	Adays.
ó	rificete be axecuted ng physician and es the buriel-transit	Exa	Sequantially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or injury that initiated evants		Dua to (or as t	a consequ	uanoa orj.					
68760,	ysick	edical	Causa (Disaase or injury that initiated evants rasulting in death) Last	C	Dua to (or as a	consequ	uanca of):					
	5 50	Ved	rasuling in death) Last		·						i	
Box	death cert e ettendin od for use	an/		d								
	0 0 2	Physiclan/M	Pert II. Other significant conditions of	ontributing to death b	ut not rasulting	in tha un	ndarlying causa g	ivan in Part I.	23b. Did to	bacco usa con	tributa to	the cause of death?
<u>о</u>	that the dended by the eached (Phy	COLDER FULL	shysem	1	01	0	Capriori	1□ Ye	8 2□No	3 Prot	bebly 4 Unknown
'n	signer bedb	Ď	Secret Emp	rysem	A . 1	304	emic	(ARDIOMY	9247HY.			
Records,	peen peen shoul	Completed	MULTI - INFAR	crden	HENT	IA.	Cepe	BROVASCU	244. Was ar perform	n autopsy ned?	COL	ara autopsy findings eileble prior to mplation of causa death?
<u> </u>	The law ate hes page 2	E	INSUFFICIEN	cy. Re.	NAL .	LUSI	JEFIC!	PIXY	1□ Ya	s 2 No	10	□Yas 2□ No
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of <	0 0	2	1 ☐ Yas 2 No	Hospital: 1 Inpatia	ant 2 ER/C	Outpatieni	i 3□ DOA O	thar: 4 Nursing Ho	oma 5 🗆 Raside	nce 6 DOthe	ar (Specify	y)
	ifing Ph n. After th funeral	ii o	27. Mannar of Deeth 1 Matural 5 □ Panding	28a. Data of Inju (Month, Da)	y Year) 28b	. Time of Injury	28c. Inju	ury at ork?	28d. Describe ho	w Injury occurre	be	
sion	Attending r death. octor: After by the fune	catl	2 Accidant Invastigatio				M 1[]Yas 2□No				
5	Direct Direct	Certification:	3 ☐ Suicida 6 ☐ Could not b 4 ☐ Homicide dataminad		ury - At homa, c. (Specify)	farm, stra	aat, factory, office	• 11	28f. Location (Str City or Town	raat <i>and</i> Numbe , Stata)	er or Rura	il Routa Number,
H		ဒီ	20- 5-45-									
D	Fur Ptur etely	edical	29a. Certifiar 1	nyaician: To tha best of minar: On tha basis of end mannar sta	f axamination a	ga, daath ind/or inv	occurrad at the trastigation, in my	time, dete end placa, opinion, daath occur	end due to the ca red at tha tima, da	usa(s) and mar ita and place, e	nnar as st end due io	ated. the ceuse(s)
	To the within To the comple	×	29b. Signatura and title of certifier	2			29c. Licer	nse number	29	d. Date signed	(Month,	Dey, Year)
			Culack	2 ATTO	PNDIL	15	DIC	0200	M	ARCH	9.1	998
1			30. Nema and addrass of person who	completed cause of d	leath (Itam 23a	(Type, F	Print)					
V			NORBERTO M.MA	CHIRAN, 1	M.D.	70	KO C M	PAIDEN C	HOICE	LA. K	SALTO	KEIS CIM O
	Sta		31. Data filed (Month, Day, Year)	B2 Flooring	ar's Signature	Ly Roll	2					
	Registr	ar	OCCI E U MAM	0								



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					State of M	arylari				Death	Wieman	Reg.	98	0	7282
			I. Decedent's Neme	(First, Middle, Las	st)		WILL.				2. Date of D Month		Day '	Yeer	3. Time of Death
	Physician		Charles	Thomas !	Harris						March	5.	1998	1001	6:00 AM
	/Medical Examine				e street and number))				4b. City, Town, o		-	4c. County o	f Death	
	Examine	т	7800 St.	Patricia	Tano					Dundal	10		D-1-	timo	ro
1		5	Social Security Nu			ne (In vrs.	last birthday	/) If Unde	r 1 Yeer		S. 8 Date of B	lirth			
	Funeral Director		216-30-2	189	2 0 F	62	Yrs.	Months	Days	Hours Mi	n. (Month, L	Day, Ye	,1935		lace (State or Foreign try) timore, MD
	show a show	1		10b. County		10c. Cit	y, Town or L	Location						1	0d. Inside City Limits
	or 28a-f s	1 2	Maryland	Balt:	imore				D	undalk					10 163 26110
	# 22 P	1	10e. Street end Num	ber				10f. Zi	p Code			10g.	Citizen of WI	het Coun	try?
	hwi 3a		7800 St.	Patricia	a Lane					21222		Uı	nited :	Stat	es
	r thems 234	1	1. Marital Status		12. Wes Decedent	Ever in U	S. 13	. Was Dece	dent of I	Hispanic Origin? an, Mexicen, Pue	(Specify Yes or N	lo-			en Indien,
21215-0020	0 0 0	2	1 Never Marrie		Armed Forces? 1 Types 2 If Yes, Give Year or Dates:					Specify:	ano racan, etc.)		Specify:	, White,	White
Ö	"natural",			15. Decedent's Ed	lucation		16a, Dec	edent's Usu	al Occur	pation		168	. Kind of Bus		
15	ed within 72 ho ygiena. her than "naturi ft, the Wood		(Specif	fy only highest gra	de completed)		(Giv	e kind of w	ork done use retire	during most of w	orking				
12	within then		Elementery/Secon	idary (0-12)	College (1-4or 4 Years	5+)	Insu	rance	Sys	tem Spec	cialist		Social	Sec	urity
	Hygiena. Hygiena. Ither the		17. Father's Name (F	First Middle (ast)						18. Mother's N	ame (First, Midd	le. Mai	den Sumame)	
an	mtal H of off	5									A. Smit			,	
3	2 should be filled and Mental Hygi Is marked other aumatic event,			. Harris						-					
, Maryland			Mrs. Jo		<i>Type, Print)</i> arris Wife	е				tricia I					
Baltimore,	ges 1 and t of Health if item 27 or other t	2	20a. Method of Dispo				lace of Disp	position (Na	me of	ca)	Date	200	Location - C	City or To	wn, State
no n				Cremation 3 ☐ 5 ☐ Other (Specifi	Removal from State		k Law				1998		Balti	more	, Maryland
三	artmen ortant: Injury		21. Signeture of Fun							-		-			
Ва	permit. Pe Departmen Important: any injury pnce.	1		muy L)					ck Fune: se Ave.					21222
		1	23a. Part1. Enter the	e disease, or com	plications that ceuse	d the deet	h. Do not e	nter the mo	de of dyi	ng, such as card	iec or respiratory	arrest,		1	Approximate Interval Between
	Physiclan		snock, or near	trailure. List only	one cause on eech I	ine.									Onset end Death
	/Medical		Immediate Cause (F	Inal		Mai	1	(Ro	ral (-00 C			- 1	C 2 /
	Examiner		disease or condition resulting in death)		a	1901	asu			lat (ell U	Wil	cer		2 contain no
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	ificate be asscuted g physician and as the bunal-transit		Sequentially list con if any, leading to imr cause. Enter Under Cause (Diseese or In thet initieted events	ditions,		Due to (d	ras e conse	equenca of):						
50,	ouria ouria		cause. Enter Under Cause (Diseese or In	tylng niury	C										
68760,	icate be physicials the bur		thet initieted events resulting in death) Li	ast		Due to (o	r as a conse	equenca of)	:					i	
-	E 000													1	
Box	attending for use e				d										
	at the death certified by the attending etached for use Bhveician/M	F	Part II. Other signific	cent conditions	ontributing to death t	out not res	ulting in the	underlying	cause gi	ven in Part I.	23b. DI	d tobe	cco use con	tribute to	the cause of deeth?
P.0	that the de ad by the addrached										11	Yes	2 1 No	3 □ Pro	bably 4 Unknown
	as that igned to be det										_				
of Vital Records,	iaw requires that the death cert as been signed by the attendim of should be detached for use										24a. Wa	as an a	utopsy	24b. W	ere autopsy findings
Ö	should	3									pe	rforme	d?	CO	ailable prior to impletion of ceuse
ec	The law requir sata has been s page 2 should													of	death?
-	The Lange page										10	Yes	2 10 No	1[Yes 2 No
i a	ysician: The		25. Wes case referre	ed to medical						28. Piace of D	eath (Check ont	y one)			
1	2 00		1 Yes 2	10	Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpati	ent 3 C	OA Ot	her: 4 \substack Nursing	Home 571	sidenc	a 8 □Othe	r (Specil	ý)
	er this neral di		7. Manner of Death		28a. Date of Inju	ury Vear)	28b. Time Injury		28c. Inju	ry at	28d. Describ	e how	injury occurre	ed	
0	afuner a funer		1 ☑Natural 2 ☐ Accident	5 Pending investigation		29 10017	iiijuiy	M		Yes 2 □ No					
Division	tal or Attending P rs efter death. el Director: After t led in by the funera		3 Suicide	6 Could not be determined	208. FIECE OF III	jury - At h	ome, farm, s	street, facto	ry, office		28f. Location	(Stree	at and Number	r or Rure	al Route Number,
á	of and and and and and and and and and and		4 Homicide		building, e	tc. (Specif	Y)				City or 1	own, s	state)		
	To the Hospital or Attending Ph within 24 hours elter death. To the Funerel Director: After th completaly filled in by the funeral Medical Certification:		(Check only		ysicien: To the best niner: On the basis of	of examina									
	thin 2 the mple		one)	dala ad an ater .	end manner st	ialeg.		- 0	Do lines	se number		204	Date signed	(Month	Day Year)
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			1V/2	n MO)				DI.	848/			3/3/	18	
	15+1	3	30. Name and addre	iss of person who	completed cause of 6836	death (Iter	23a) (Type SPIT	e, Print) AL T	RIV	E, 13	BALTO,	m	カショ	23	7
	State	:	31. Date filed (Month		32. Pogist	rar's Signa	iture								
	State Registrar		MAI	R 0 9 199	8 Silia	Devil	man Par	nda 22							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 26 per M.D. G-757 3/9/98 reb 1. Decedent's Nama (First, Middle, Last) Reg No. 2. Dete of Deeth 3. Time of Death Month Dev Yee **Physician** Roy James Hammon, Jr. February 15, 1998 12:30AM /Medical 4a Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Transitional Care Unit Baltimore MD If Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, Yaar) Birthplaca (Stete or Foreign Country) **Funeral** 1KXM 2□ F Months Deys 520-26-5246 Director Oct. 13, 1931 California Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours effar deeth with the Meryland nent of Health and Mantal Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28s-f show 10d. Inside City Limits 10a State 10h Count 10c. City. Town or Location r 28a-f show 1 ☐ Yes 2 ☐ No Director Baltimore Freeland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? *natural", or items 23s or 1308 Walker Road 21053 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forcas? Y☐ Yes 2☐ No 1YYas, Giva Year or Detes: ¹50-¹55 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced the Medical Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede complated) College (1-4or 5+) Elementery/Secondery (0-12) Shipyard/Petroleum Pipe Fitter Is marked other 18 Mother's Name (First Middle, Maiden Sumeme) 17. Fathar's Nema (First, Middla, Last) Roy James Hammon, Sr. Bernice Irene Bechtol 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 1308 Walker Road, Freeland, MD 21053 Joanne Hammon/Wife Item 2 20b. Placa of Disposition (Neme of cemetery, crematory or other pleca) 20e. Method of Disposition 2/18/98 Date 20c. Location - City or Town, Stata 1 □ Burial 2 □ Cremetion 3 □ Removel from State = 6 permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Jessup United Methodist Ch.Cem. Sparks, MD 22. Nama and Addrass of Fecility 21. Signeture of Funerel Servica License Michael J. Flagle Flag Lemmon Funeral Home Plchael J. Flagle 10 W. Padonia Rd., Timonium, MD 21093

23a. Partl. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.

Approximately a such as cardiac or respiratory errest. **Physician** /Medical Immadiate Ceuse (Finel diseese or condition resulting in deeth) Examiner Examiner physician and the burial-transit requires that the death cartificete be axecuted Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated evants resulting in deeth) Lest Due to (or as a consequenca of): P.O. Box 68760. Physician/Medicai Dua to (or as a consequenca of) Ses esn signed by the a 23b. Did tobseco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 12 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings sveilable prior to complation of causa of death? Completed 24e. Wes en eutopsy performed? The law ils certificate has 1 Yes 2 No 1 Yes 2DNo or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home Analysidence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation ector: / 2 Accident in 24 hours.
The Funeral Director of the Funeral Direc 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the causa(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the causa(s) and menner stated. 29a. Certifier Medicai To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29d. Data signed (Month, Dev. Year)

State Registrar

Angistrar's Signature Handell

5001

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

Harlin

29c. Licanse number

hoch

20396

Raren

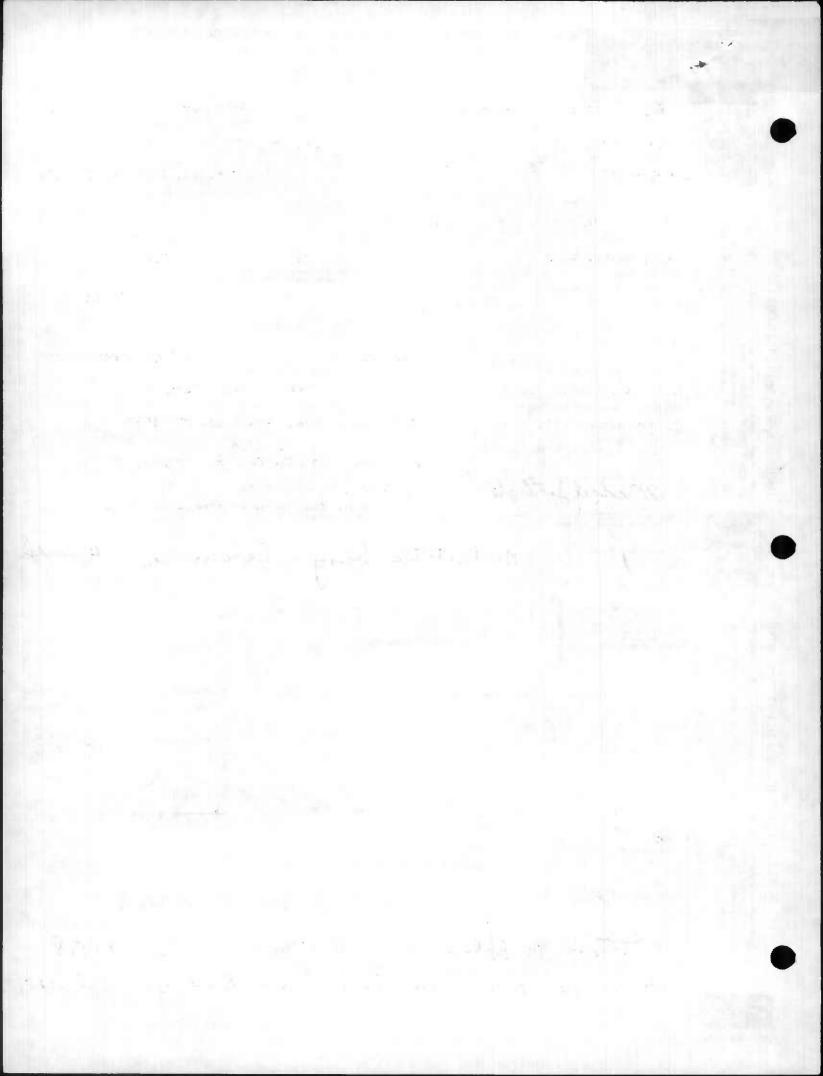
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29b. Signeture and title of cartifier

Davis

31. Dete filed (Month, Dey, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First Middle Last 2. Date of Death **Physician** 5:00 DM /Medical 4b. City, Town, or Location of Death Examiner Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F 218-28-3480 Yrs Director 19,1900 June unknown Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Anne Arundel Crownsville 10e. Street end Number 10f. Zin Code 10g. Citizen of What Country? with 8 1454 Fairfield Loop Road 21032 U.S.A. 238 death Funeral 12. Was Decedent Ever in U,S.
Armed Forces? unknown
1 □ Yes 2 □ No
If Yes, Give
Year or Dates: or items 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unknown 14. Rece - American Indien, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No A Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If tem 27 is merked other than 'n any injury or other traumstic avant Elementary/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 unknown unknown 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) unknown unknown 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) in state eph B Van Sant 22. Name and Address of Fecility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** conorary vascular disease /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) physician Box 68760. requires that the death certificate be Physician/Medical the Due to (or es e consequence of): SE attending 950 Por signed by the a Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of meath? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? Completed peen s The law has page 2 certificata 1 ☐ Yes 2 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, it 25. Was pase referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA for of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and plece, end due to tha cause(s) end manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day

Please Tape or Print in Black Indelible Ink. Assure All Copies Are Legible. ate of Maryland / Department of Health Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death **Physician** Month CARLTON HAYNIE 50 26 /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner BON SECOURS HOSPITAL BALTIMORE Baltimore City If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Sociel Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 213-28-5258 66 Yrs. unknown Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. insida City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director BALTIMORE Baltimore City 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? ö Permit. Pages 1 and 2 should be filed within 72 hours after death will Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or itams 23a c any injury or other traumatic event, it 1025 N 21217 CAREY 57 U.S.A. 12. Was Decedent Ever in U,S.
Armed Forces? unknown
1 | Yes 2 | No
If Yes, Give
Year or Dates: 13. Was Decadant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Navar Married 2 Marriad Baltimore, Maryland 21215-0020 1 Yes 2√2 No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Malden Surname) unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown unknown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ➡Other (Specify) in state 21. Signature of Funeral Service Licenses
Joseph B. Van Sant State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Kny 23a. Part . Entar the disease, or complications that cadsad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final diseese or condition resulting in death) e. Acute Gangrenous

Due to (or as e consequence of): chole cystitis Examiner Examiner ettanding physician end for usa as the bunal-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Records, P.O. Box 68760 rneumonitis Completed by Physician/Medical renal Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco usa contribute to the cause of death? Yas 2 No 3 Probably 4 Unknown cardiomyopathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Gastrointestinal bleeding alcoholism 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this cartifics complately filled in by the funeral director, 25. Was case referred to medical examiner?
Yes 2□ No
27. Manner of Death Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not ba determined 3 Sulcide 28e. Placa of Injury - At home, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatura and title of certifian 29c. Licanse number 29d. Data signed (Month, Day, Year) moges Gebre mariam: 460Wilkers Are Belto 21229
31. Date filed (Month, Day, Year) 32. Registrar's Signature State Julie Beinden-Randelle

DHMH 16 Rev 6/95

Registrar

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State Registrar

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29b. Signeture end title of certifier

31. Dete filed (Month, Dey, Year)

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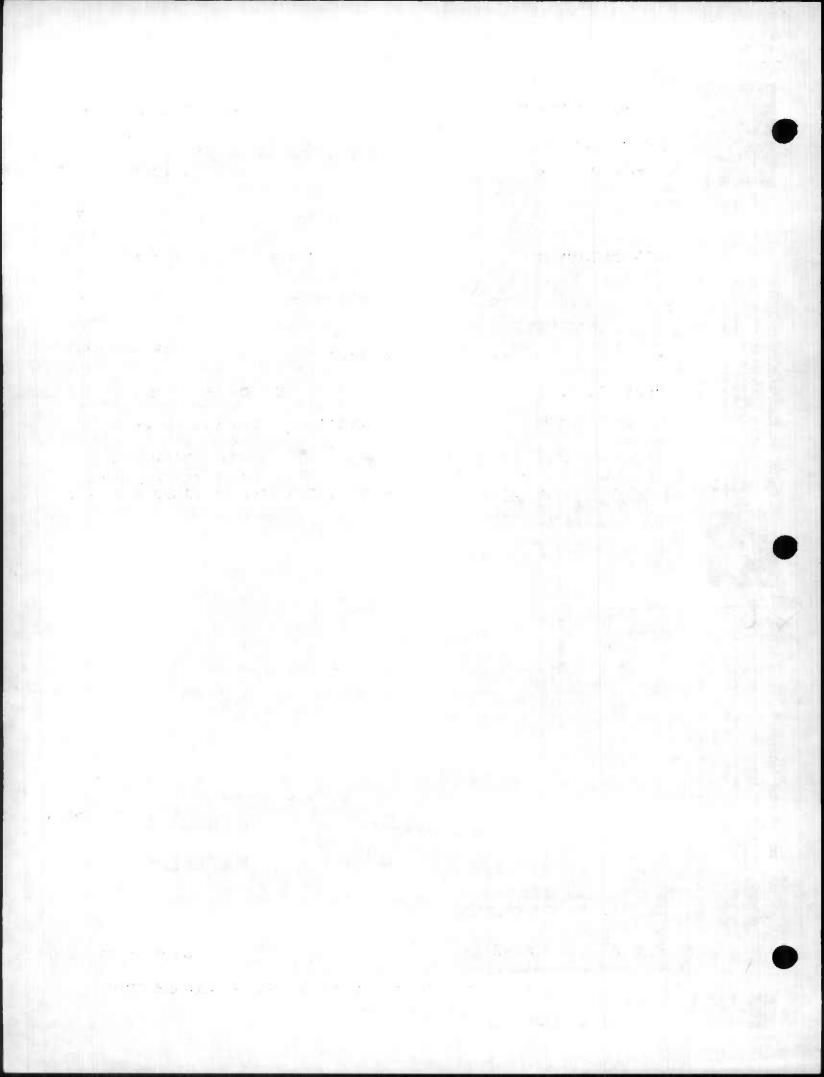
30. Name end eddress of person who completed cause of deeth (Item 28a) (Type, Print) Radentz

29c. License number

OCME

29d. Date signed (Month, Dey, Year)

MARCH 03, 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month WILLIE JONES 1998 mouch 4a. Facility Neme (If not institution, give straet end numbar) 4b. City, Town, or Location of Death 4c. County of Daeth UNION MEMORIAL HOSPITAL N/A BALTO If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) JAN 29, 1916 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foraign Country) Deys XXM 2□ F 215-09-2198 Yrs. SC Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A XXYes 2 No BALTO 10e. Straet and Number 10f. Zip Code 10g. Citizen of What Country? 1810 E. 29TH ST 21218 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Bleck, White, etc. 1 Nevar Merried 2 Married Yes 27 No f Yes, Give Year or Detes: 1 Yes 2 No Specify: Specif BLACK 3 Widowed 4 □ Divorced 16e. Decadent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementery/Secondary (0-12) 4th STEEL CO STEEL WORKER 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) JEFF JONES LUCINDA JONES 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Reletionship (Type, Print) MINNI ALSTON 1810 E. 29th ST BALTO, MD 21218 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata MAR Dete 0 Bunal 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) MT ZION CEM 1998 BALTO, MD 21. Signeture of Figneral Service Licenses 22. Name and Address of Fecility BETTS FUNERAL HM 1129 N. CAROLINE ST BALTO, MD 21213 Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart fellure. List only one ceuse on each lina. Approximete Intervel Between Onset and Deeth Immediate Cause (Final diseese or condition resulting In death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Part II. Other significent conditions contributing to death but not resulting in the undariying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Was an eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 2 No 1 Yes 2 No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Supatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending investigation Deturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be determined 28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Streat and Number or Rurel Route Number, City or Town, State) 4 Homicide

Be Completed by Physician/Medical Examiner the buriel-tren Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 bours after death. with the Furnaral Directors. After this certificate has been signed by the ettending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

28a-f show ns 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours effer c Depertment of Health and Mental Hygiene. Important: If Item 27 is merked other than "naturel", or iten any Injury or other traumatic event

Physician /Medical

Examiner

Maryland 21215-0020

Baltimore,

Director

by Funeral

Completed

Be

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifiar

Descripting Physicien: To the best of my knowledge, death occurred at the time, determine the first place, and due to the cause(s) and manner stated.

2 ☐ Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number

😕 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

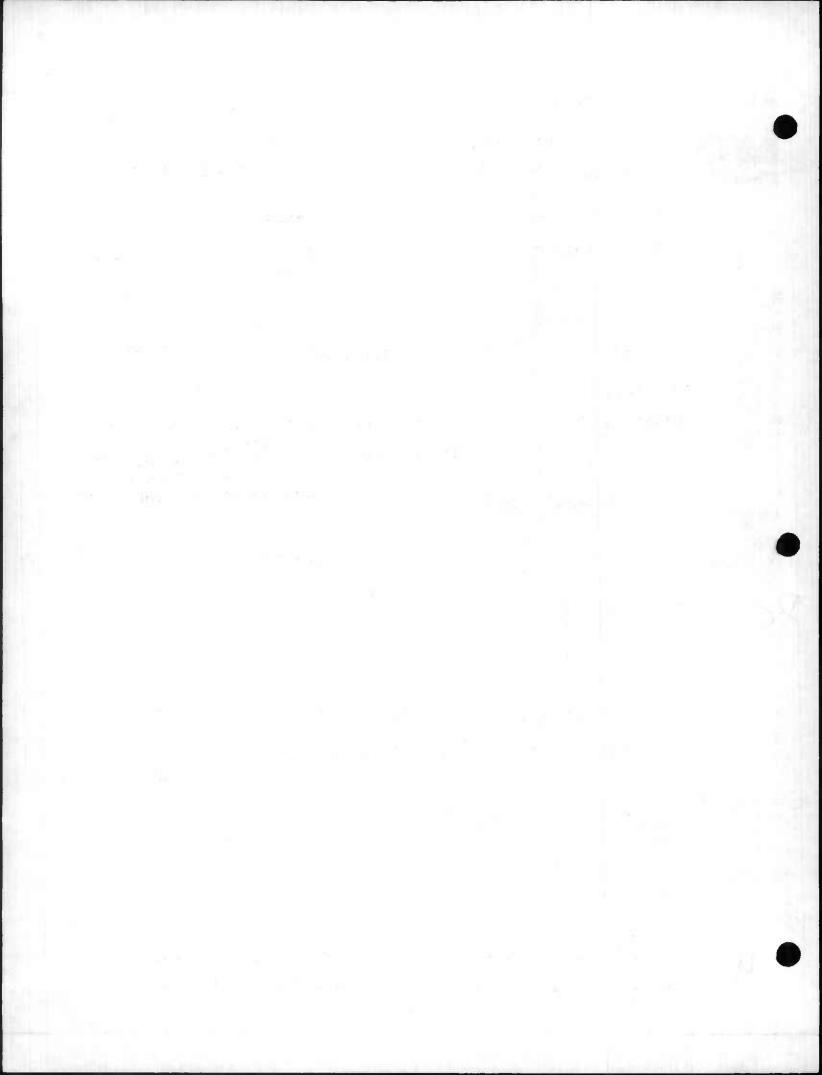
29d. Dete signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Condi Memorial Hospital 2018, University Parkusy 31. Dete filed (Month, Dey, Yeer)

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32. Agistrer's Signature



State Registrar

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30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

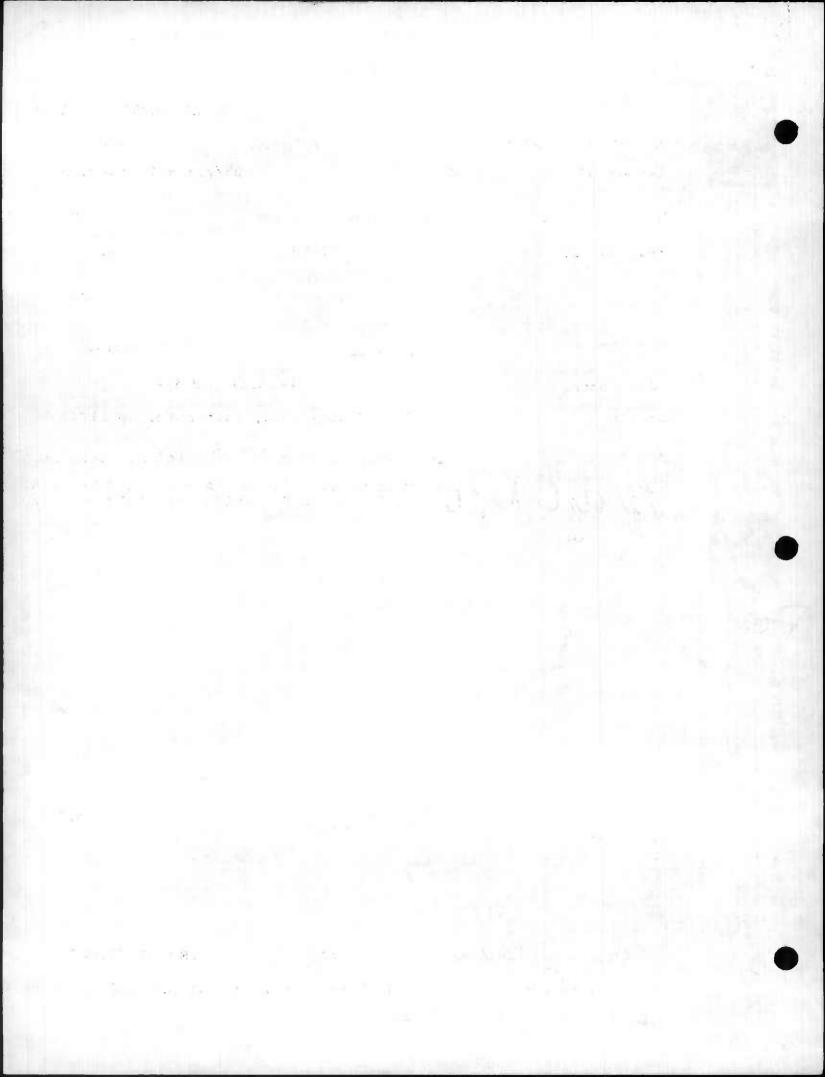
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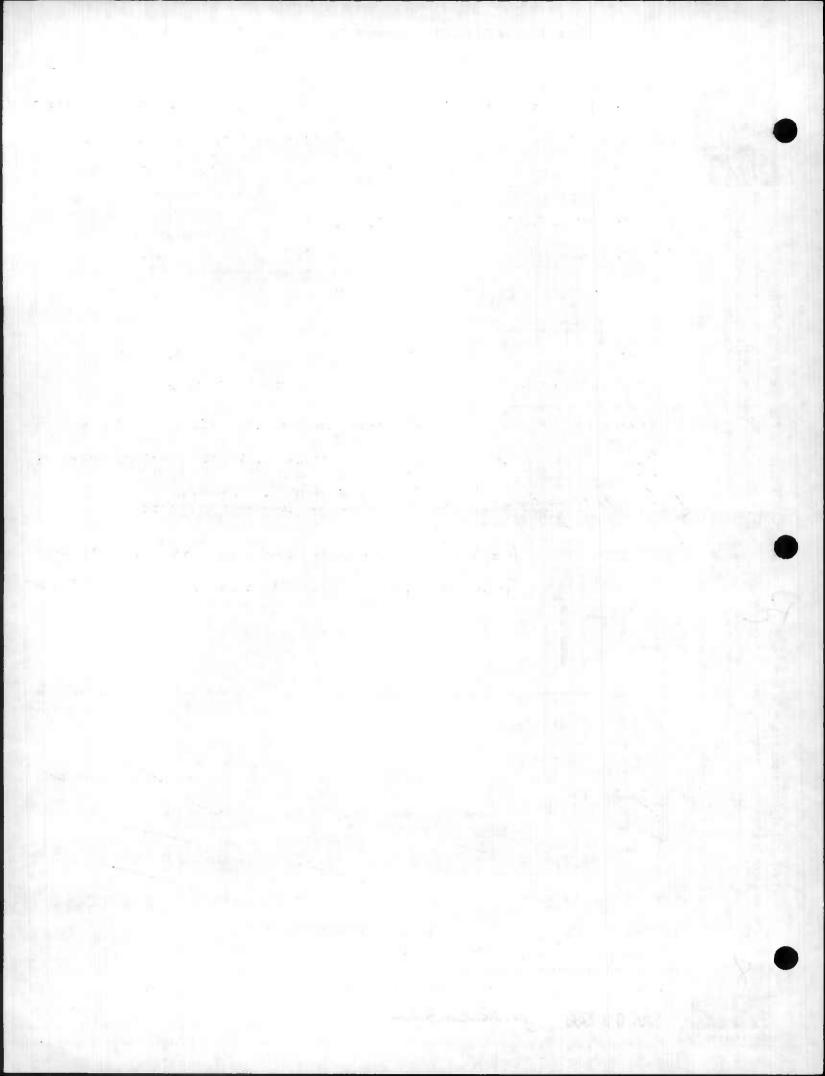
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FEBRUARY 28, 1998



State of Maryland / Department of Health and Mental Hygiene 9 8 0 7 2 8 9

			C	ertificate d	of Death	Re	eg. No.	01203
Physician	1. Decedent's Name (First, Middla, L William T	nomas Lowe, J	r.			2. Date of Deat March 5		3. Time of Death 8:13 a
/Medical Examiner	4a Facility Name (If not institution, g 4655 Manor Lane	va street and number)			4b. City, Town, o	r Location of Death	4c. County of Howard	
Funeral Director	5. Social Security Number 6. 212–34–4311	Sex 7. Age (In	yrs. last birthde Yrs.	Months Da	ear If Undar 24 Hr	s. 8. Date of Birth	Year) S	Birthplace (Stata or Fore
M til	Usual Residence of Decadent 10a. Stata 10b. County	100	. City, Town or	Location				10d. Insida City Lim
Se-f sh offilied		County		Ellicott				1 Yes 2 X
r items 23s or 25s-f s direct rount be notified Funeral Director	10e. Sireel and Number 4655 Manor Lane			10f. Zip Cod	21042	1	0g. Citizen of Wh USA	at Country?
0 9	11. Marital Status 1 Never Married **Married 3 Widowed 4 Divorced	12. Was Decedani Evar Armed Forces? XXXYes 2 ☐ No If Yes, Give Yaar or Dalas:	in U,S. 1:	3. Was Decedent If Yes, specify (of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yas or No- into Rican, etc.)		American Indian, Whita, etc.
natura edical	15. Decedent's I (Specify only highast g	Education rada complated)	/Gi	cadant's Usual Oc va kind of work do a. DO NOT usa ra	one during most of w		16b. Kind of Bush	naas/Industry
nt, the Medical Completed	Elamentary/Secondary (0-12)	Collage (1-4or 5+)		emoly	lireo)		Electro	nics
marked other than 'natural', umatic event, the Medical Exa To Be Completed by	17. Falhar's Name (First, Middla, Las William Thom	•				ame (First, Middla, M tine Hern		
is meri	19a, fnformant's Name/Relationship	(Type, Print)	19b. Ma	ailing Address (St	raat and Number or I	Pural Routa Number	, City or Town, St	ata, Zip Code)
important; if from 27 is merced other transments any lojury or other traumatic event, the Medical once. To Be Completed	Ms. Rhonda Lowe/ 20a. Method of Disposition 1 Provided 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	y, MD 21 20c Location - Co Elkrido						
ing physicien and a set the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due	to (or as a cons	sequance of):	ciral I	andar D		3 days
Su S	Part fl. Other algnificant conditions	contributing to death but no	resulting in the	undariving cause	e given in Part I.	23b. Dfd to	bacco use contr	ibute to the cause of dea
igned by the attendible detached for us.						1 🗆 Y	Probably 4 Denkin	
2 should						24a. Was a perform		24b. Wera autopsy finding available prior to completion of cause of daath?
director, page for Be Com			The			1 🗆 Ye		1 Yas 2 No
al director, pag	25. Was case refarred to medical examiner? 1 No 2 No	Hospital:	2 ER/Outpat	tient 3 DOA	Othor:	eath (Chack only on Home 5 Preside		(Specify)
After the funerel funerel	27. Manner Death 1 Natural 5 Pending 2 Accident Investigati	28a. Date of Injury (Month, Day Yas	r) 286. Time Injur		Injury at Work? 1 Yes 2 No	28d. Describe ho	28d. Describe how injury occurred	
Medical Certification:	3 ☐ Sulcide 6 ☐ Could not 4 ☐ Homicida determine		At homa, farm, pacify)	streat, factory, of	ice	28f. Location (St City or Town	traat and Number n, Stata)	or Rural Routa Number,
Pletely filled edical C	29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☑ Medical Exa	hyelcfan: To tha best of my mfnar: On the basia of axar and manner stated.	knowledga, de mination and/or	eath occurred at the Invastigation, in r	e time, data and pla my opinion, death oc	ce, and due to tha courred at the tima, d	ausa(s) and mannate and placa, an	ner as stated. d dua to tha cause(s)
To the Fu complete	29b. Signature and title of cartifier	m ms	Pyrit]	D31473		9d. Data signed of	(Month, Day, Year)
State	30. Name and address of person who Patryce A. Toye, 31. Date filed (Month, Day, Yaar)		Med. E		rd County	, Hemloc	k Cone y	Vay, E.C., M 21042



Funeral

Director

the

7 is marked other than "natural", or items 23e or 28a-f show traumatic event, the Madical Examiner must be notified at

oe filed within 7 (al Hygiene.

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If fem 27 is marked other
any injury or other treumatic event

Physician

/Medical

Examiner

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physician

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certificate

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98 for use as

Box 68760

Division of Vital Records, P.O.

The

Attending Physician:

As Hospital or Alt.

24 hours after death.

vel Director: Alte.

's by the IV.

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Day Vaa **Physician** Theodore Lanasa February 27 1998 /Medical 10:18 PM 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Fort Howard Baltimore VA MHCS FORT HOWARD DIVISION If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Data of Birth (Month, Dey, Year) 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) Days Months Hours 1 M 2 F Yrs. 215-22-7296 Jan. 2, 1927 71 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore City Baltimore 1 Yes 2 No Director 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 21214 U.S.A. 2806 Echodale Avenue Funeral Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status unknown 12. Was Decedent Ever In U,S. Armed Forces? 14. Rece - American Indian, Bleck. Whita, atc. 1 ☑ Yes 2 ☐ No If Yes, Give Yaer or Detes: 1945 1 Navar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White P 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Marie Brady Frank Lanasa 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code, 1436 Henry Street, Baltimore, Maryland 21230 Frank Lanasa/brother 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Buriel 2 ☐ Crametion 3 ☐ Removal from Stete 4 Donation 5 ☐ Other (Specify) State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA WEEKS Due to (or as a consequence of) Examine Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that instated events) Due to (or as a consequence of): Congestive Heart Failure Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ð 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 9 □ No 1 Ves 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ★★npatient 2 ER/Outpatient 3 DOA Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Kcertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) end menner stated. 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year WAR 0 9 1998

Fahed Kouli, MD 9600 North Point Road, Fort Howard, MD 21052 82. Radistrar's Signature

30. Neme and eddress of person who completed cause of death (item 23a) (Type, Print)

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UNK. 98-051 wlc 98-12 ROY M

Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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LLER JR				Certificate of	f Death	Reg	J. No. 9 0	U	1291			
	1. Decedent's Name (First, Middle, L	ast)				2. Dete of Deeth	Devi	Vasa	3. Time of Death			
Physician	Roy Eugene	Miller	Jr.			Month March 5	Dey 1998	Year	1005p			
 /Medical Examiner 	4e Facility Neme (If not institution, gi	ive street and number)			4b. City, Town, or		4c. County o	of Deeth	тооэр			
Examine	8904 HARFORD ROA	AD.			Baltim	ore	BALTI	MORE				
Funeral	5. Sociel Security Number 6.	Sex 7. Age	e (In yrs. last bir	thday) If Under 1 Yes	ar If Under 24 Hrs	8. Date of Birth			ce (State or Foreign			
Director	219-04-5374	1 ⊠ M 2□ F	28	Yrs. Months Dey	S Hours Mill	March 18	1969	VA				
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or 28a-f si be notified Director	MD Baltin	nore	Dund									
Dire	1706 Ditto Dd			10f. Zip Code		109	g. Citizen of W	het Country	y?			
ral	1706 Rita Rd			2122			USA					
r Rems 23.	11. Marital Stetus	12. Wes Decedent 8 Armed Forces?		13. Was Decedent of If Yes, specify Cu	f Hispenic Origin? (S uban, Mexican, Puer			 American White, et 				
Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		1 Yes 2 N If Yes, Give Yeer or Dates:	No	1 ☐ Yes 2 🖾 N	lo Specify:		Specify:	Wh	ite			
dical	15. Decedent's E (Specify only highest go		16e.	Decedent's Usuel Occ (Give kind of work don	supation ne during most of wo		6b. Kind of Bus	siness/Indu	stry			
end Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show summit event, the Medical Examiner must be notified at To Be Completed by Funeral Director	Elementery/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT use reti	red)							
Cor Cor	12		F	ireman	10.14.11.11.11	В	altimo	ore (City			
dott Be	17. Father's Name (First, Middle, Las	•				me (First, Middle, Me		3)				
Ment Merke	Roy Eugene Miller Sr. Ivy Lea Harmon											
I s II	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Veronica Miller / wife 1706 Rita Rd Baltimore, MD 21222											
Haalt m 27 ther	20e. Method of Disposition	.er / wi		1/06 Rita Disposition (Neme of	Rd Ba		MD 21 oc. Location - 0		n State			
or it of	1 Buriei 2 Cremetion 3	☐Removel from State	cemeter	ry, cremetory or other p		Mar. 9	C. Location - C	Sity of FOW	n, Stele			
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168	23a. Pert1. Inter the disease or cor shock, or heart feilure List only	npiicetions that caused y one cause on each lir	the deeth. o	not enter the mode of d	lying, such es cardia	c or respiretory erres	t,	1 1	Approximete Intervel Between			
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Medical xaminer	Immediate Ceuse (Final disease or condition	THERM	AL INJU	RIES				i				
	resulting in deeth)	V.	Due to (or as e	consequence of):								
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hysicien and the burial-transit dical Examir	Sequentially list conditions, if any, leading to immediate		Due to (or es e	consequence of):								
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d by the ettanding platached for usa as Physician/Me	Pert II. Other significant conditions	contributing to death be	ut not resulting in	the underlying cause	given in Pert I.	23b. Did tob	acco yae con	tributa to t	he cause of death?			
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a 2 sl	0.00								eth?			
sate has been s. page 2 should Completed						1X Yes	2 🗆 No	X	Yes 2□ No			
artific actor Be	25. Wes case referred to medical examiner?	112.1			D	eth (Check only one						
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ar this cartific naral director.	27. Menner of Deeth	28a. Date of Injur		Firme of 28c. In	ijury at Vork?	28d Describe hov	/ Injury occurre	bed				

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Medicai Certification 10

28f. Location City or To 10a 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the ceuse(s) end menner stated. 29d. Dete signed (Month, Day, Year)

1 Yes

29c. License number March 8, 1998 O.C.M.E.

street, fectory, office

J. Laron Locke M.D., 111 Penn Street, Baltimore, Maryland 21201

Registrar

31. Dete filed (Month, Day, Year) MAR 0 9 1998

5 Pending investigation

6 Could not be determined

1 Naturel

Accident 3 Suicide

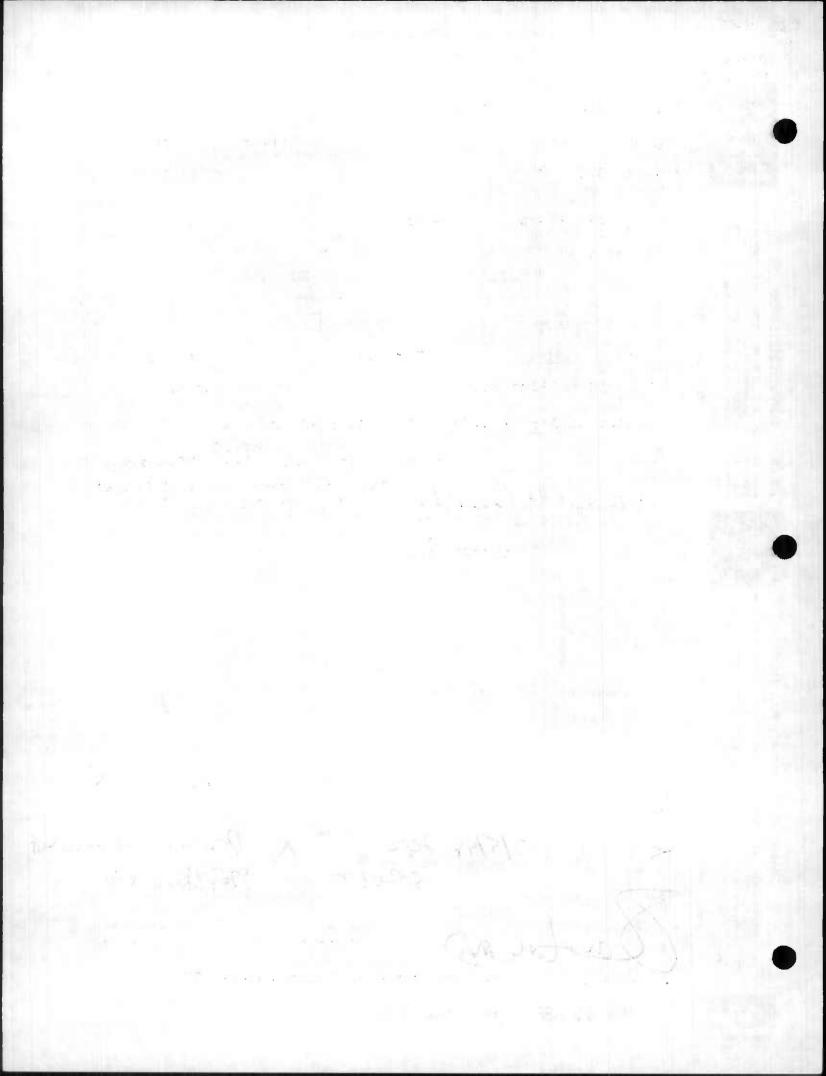
4 Homicide

29b.



98

Piece of injury - At home, farm, building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month MARCH **Physician** 6:37 Pu CASSIE MOYER 06, /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner CENTER RANDAIISTOWN NORTH WEST BALTIMORE HOSPITA! If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. lest birthday) 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** 1□M 2 F Months Deys 232-52-7626 Director NORTH CAROLINA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "naturel", or itema 23a or 28a-f show traumatic event, the Modical Examiner must be notified as 1 XYes 2 □ No MARYLAND BALTIMORE Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? death with USA DRIVE 21207 6737 Chisholm Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian 11. Maritel Status Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No altimore, Maryland 21215-0020 Specify: Specify: BLACK by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any injury or other traumatic event, the Heal once. Elementary/Secondary (0-12) College (1-4or 5+) 5 44 HouseKeeper HomeMAKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be hee MARTIN HARRIETT WILSON 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reietlonship (Type, Print) 6737 Chisholm DR., BALTIMORE, Md. 21207 SON LEONARD MOYER -20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Cemetery 3/12/98 STONE VILLE, N.C. 22. Name and Address of Facility DERRICK C. JONES FUNERAL 21. Signeture of Funerel Service Licensee HOME, 4611 PARK Heights Ave., BALTIMORE 23a. Pentl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician /Medical Immediate Ceuse (Finet PNETUNONIA 1 mel disease or condition resulting in death) Examiner Examiner burial-transit and Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initioted events resulting in deeth) Lest Due to (or es e consequence of): physician Box 68760 Physician/Medical the Due to (or es e consequence of): SE esn Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? Records, P.O. 1 Yes 20 No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 ☐ Yes 2 TNo 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medical examiner? 1 Yes 2 No or Attending Physician: funeral director. Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1\2 Inpatient 2 2 ER/Outpatient 3 DOA this 27. Menne of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation After 1 Naturel s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 | Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted. 29a. Certifier edical completaly 2 Nedical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. (Check only one) To the I within 2 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar

Month, Day, Year,

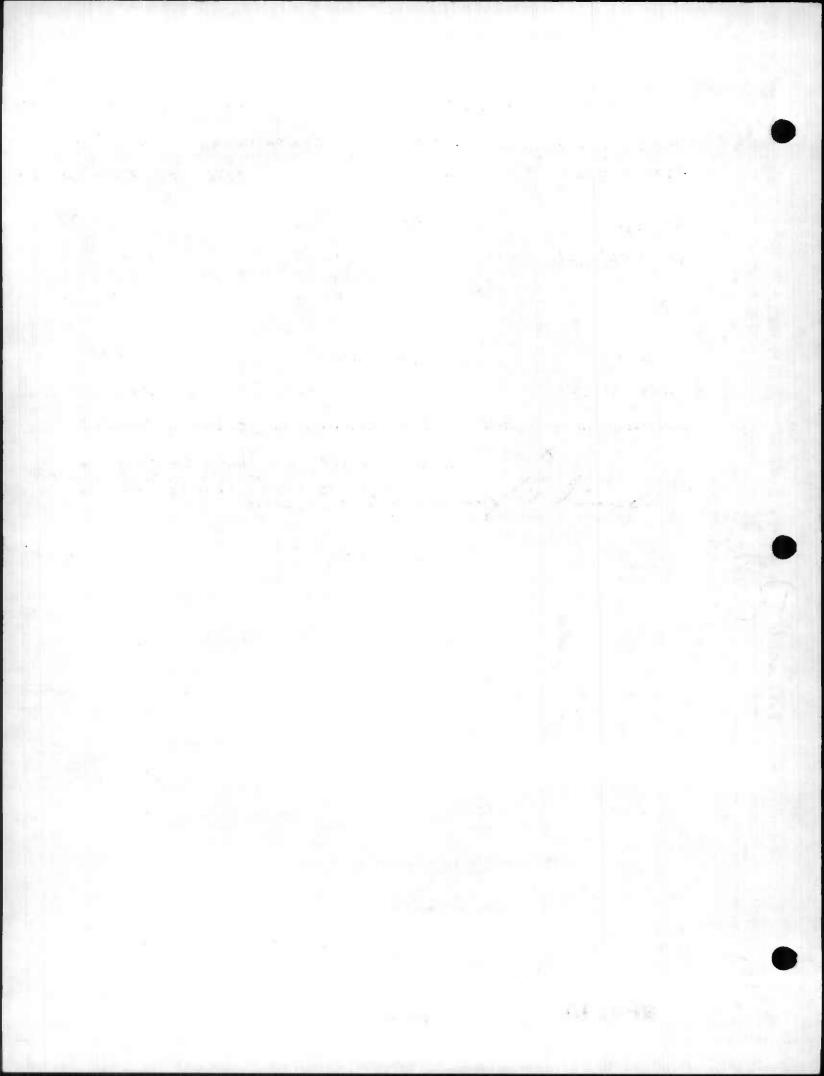
29b. Signeture end tiple of certifier

MPERIOR Registrer's Signature

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

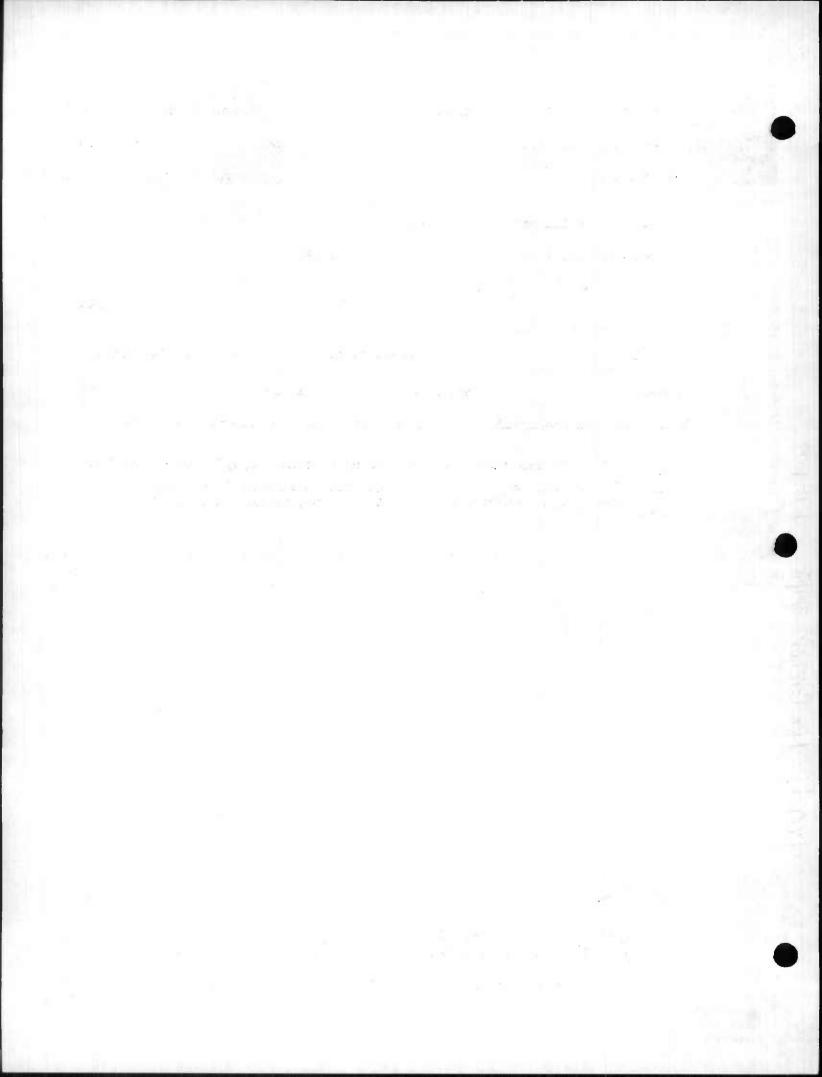
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State of Maryland / Department of Health and Mental Hygiene

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- 3	Physici /Medi		DONALD	л. м	iacGRI	EGOR			Month	Day 4, 1998	Yaar	1:15 PM
-	Examir		4a. Facility Nama (If not institution, giv	a street and number)				4b. City, Town, or	Location of Dear	th 4c. County	of Death	
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Sal S	Sepa mpor my Ir		21. Signature of Funaral Sarvice Licer	isaa C		2	22. Nama and Add Ruck Tow	rass of Facility Son Funer	al Home	, Inc.		
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	/Medical Examiner		Immediata Causa (Final disaasa or condition rasulting in daath)	a W C	her	ri	c CAr	diomy	10 pn	Thy	1	1 years
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w	death certificate be axecuted e attending physician and of for usa es the buriel-transit	Examiner	Sequantially list conditions, if any, laading to immadiata	0	Dua to (or a	as a conse	aquance of):				1	0
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25	ding Ph h. After th funeral	lo Lo	1 Natural 5 Panding	28a. Data of Injury (Month, Day	Year)	8b. Tima Injury	W		280. Dascribe	how injury occur	rea	
sic	eath or:	cat	2 Accident investigation 3 Suicide 6 Could not b		4.1			Yas 2 No	Opt Leasties	(Chan at an of Alicent	har as Owe	I Courte Alventon
Division	or Attendent efter deat Director:	Certification:	4 Homicida datarmined	building, atc.	ry - At nom . (Spacify)	ia, rami, s	treet, factory, office			(Street and Numb wn, Stata)	er or nura	r Houta Warniber,
	pital ours eral C	ŏ	29a. Cartifiar Cartifying Ph	ysician: To the best of	f m km mude	adaa daa	th accurred at the	time, data and place	and due to the	anuna(a) and mu	000010001	totod
	To the Hospital or Att within 24 hours effer of To the Funeral Direct completely filled in by	edical		ninar: On the basis of a and mannar state	axaminatio							
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death

attending physician end for use es the bunel-transit The law requires that the death certificate be executed the a signed by peen s hes page 2 certificate Physician: this funeral I Director: After the or Attending deeth. efter 24 hours

3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** Helene Joyce Mignini March 4 1998 9:45 am /Medical 4a Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 9010 Carlisle Avenue Perry Hall Baltimore If Undar 1 Yaer | If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 280 F 220-22-3929 Yrs. 69 9/7/1928 Maryland Director Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f show 7 is marked other than "naturel", or items 23a or 28a-f show traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Director Perry Hall 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours effer deeth v
Department of Health and Mental Hygiene.
Important: If item 27 is merked other than 'naturel', or items 23s
any Injury or other traumatic event, the Medical 9010 Carlisle Avenue United States 21236 Funeral 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: by White 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Nama (First, Middla, Meiden Sumeme) 17. Fathar's Neme (First, Middla, Last) John F. Herbert Estella M. Viessman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Paula J. Clark /Daughter 62 Springtime Way Baltimore, Md. 21234 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Gardens of Faith Cem. 3/7/98 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryland 22. Name end Address of Fecility Leonard J. Ruck, Inc. 21. Signeture of Funeral Sarvice Licensea Mark T. Zavoyna mails T. 23a. Pert1. Enter the diseasa, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 5305 Harford Road Baltimore, Md. 21214 Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediata Causa (Final diseese or condition resulting in death) rectae CA. **Examiner** Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of): Box 68760. that initieted avents resulting in deeth) Lest Due to (or es e consequence of). 23b. Did tobacco use contribute to the cause of death? Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes cese referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No OL 1 Inpatiant 2 ER/Outpetient 3 DOA 28d. Describe how injury occurred 27 Menner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury ef Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No

3 ☐ Suicide 4 Homicide 29a. Certifier (Check only one)

2 ☐ Accident

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) end menner steted. 29b. Signature and title of certifie

6 Could not be determined

0 9 1998

29c. License number

Descritying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

29d. Data signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

George E. Lowe M.D. 7672 Belair Road 31. Dete filed (Month, Day, Year)

Baltimore, Maryland

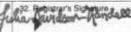
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completely

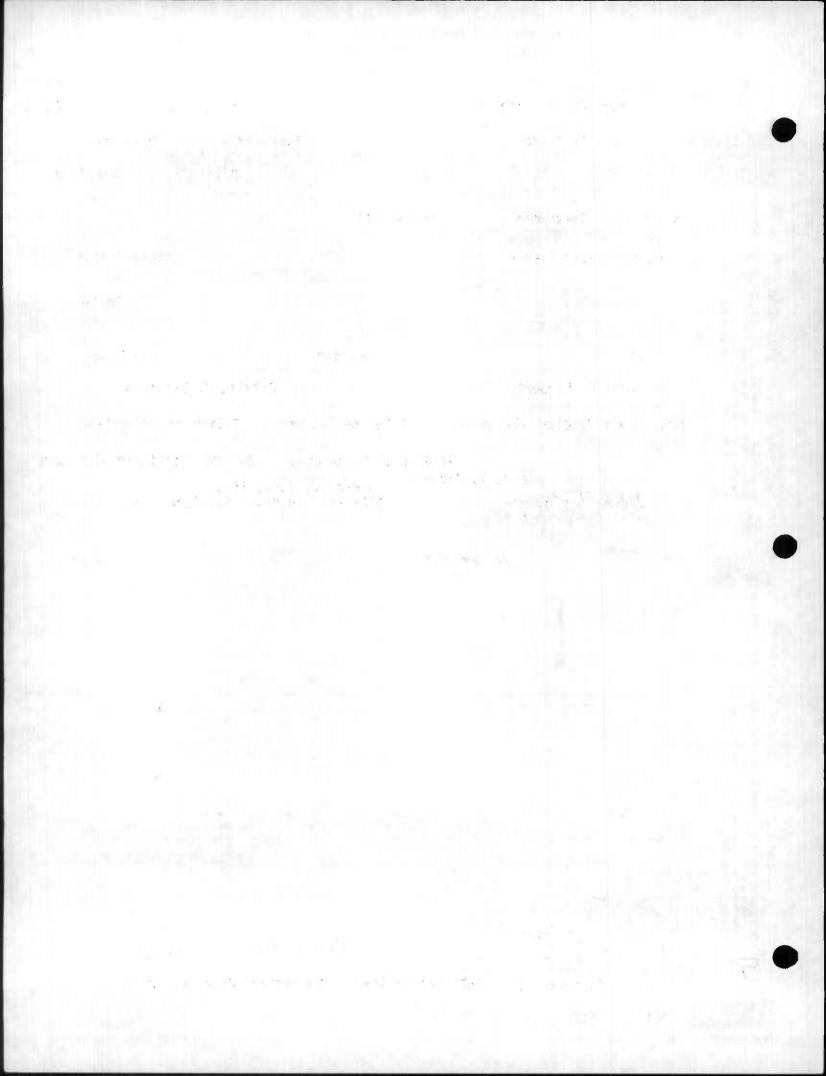
within 2

10

edicai



28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



	ype of I thit in black indenbie ink. Assure						
	State of Maryland / Department of Health and	Mental Hygiene	98	7	2	9	5
	Certificate of Death	Reg. No.		, ,	fine)	V
est)		2. Dete of Deeth		3.	Time	of D	96

Physician /Medical Examiner

Director

Funeral

by

Completed

Month

9.00 AM

10d. Inside City Limits

White

21214

6 DAYS

1 X Yes 2 No

N/A

Funeral Director

hours after

7 is marked other than "natural", or items 23s or 28s-1 show treumstic event, the Mountal Examinal must be notified at permit. Peges 1 and 2 should be filed within 72 h
Department of Health end Mental Hygiene.
Important: If Item 27 is marked other than "natu
any Injury or other treumatic event, the Medical
once.

Saltimore, Maryland 21215-0020

Box 68760

P.O.

Division of Vital Records,

Physician /Medical Examiner

Examiner The law requires that the death certificate be executed physician end the burief-trans Physician/Medical 89 p Completed hes page 2 Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificaletely filled in by the funeral director. Be Certification: To Medical To the Hosp within 24 hor To the Fune completely fi

1. Decedent's Neme (First, Middle, Li MACCT BERNADINE MARCH 4e. Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore City Good Samaritan Hospital 7. Age (In yrs. lest birthday) H Undar 1 Year If Under 24 Hrs. Months Deys Hours Min. Month, Dey, Year) Mar. 4, 1932 5. Social Security Number Birthplsca (Stete or Foreign Country) 1□M 2⊠F 217-26-7396 Baltimore, Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore City N/A Md. 10e. Street and Number 10f. Zin Code 10a. Citizen of Whet Country? 21239 1805 Wadsworth Wav United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - Amarican Indian. 11 Marital Status 1 Nevar Married 2 Merried 1 ☐ Yas 2 🕱 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) George Dernoga Anna Kuzniarski 19a. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) John S. (Husband) 1805 Wadsworth Way Macci Baltimore, Maryland 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 X Buriel 2 ☐ Cremetlon 3 ☐ Removal from State Gardens of Faith Cemetery 3/10/98 Baltimore Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Milton, J Knight Jr 22. Name end Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 23a. Pert1. Enter the disease or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause of each line. Immediate Csuse (Finel disease or condition resulting in death) MYOCARDIAL INFARCTION Due to (or es e consequence of) DISEASE CORONARY HEART Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceusa (Disease or Injury Due to (or es e consequenca of) thet initieted events resulting in deeth) Lest Due to (or es e conseguance of)

23b. Did tobscco use contribute to the csuae of death?

Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. CONGESTIVE HEART

F-AIL URE

24e. Wes en eutopsy 24b. Were sutopsy findings eveilable prior to completion of causa of deeth? performed'

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown

25. Was case referred to medical exeminer? 1 Yes 2 No

5 Pending Investigation

28e. Dete of Injury (Month, Dey Year) 6 Could not ba 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Hospital: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of Injury 28c. Injury et Work?

1 TYes 2 No

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

1 ☐ Yes 2 🖾 No

29a. Certifier (Check only one)

27. Menner of Deeth

1 Naturel

2 Accident

3 ☐ Suicide

4 Homiclde

1 No Certifying Physicisn: To the best of my knowladge, death occurred et tha tima, date end place, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end placa, end due to the cause(s) end menner stated.

29b. Signature and titla of certifier

29d. Data signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

momas

M.D

P10582

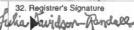
7th, 1998

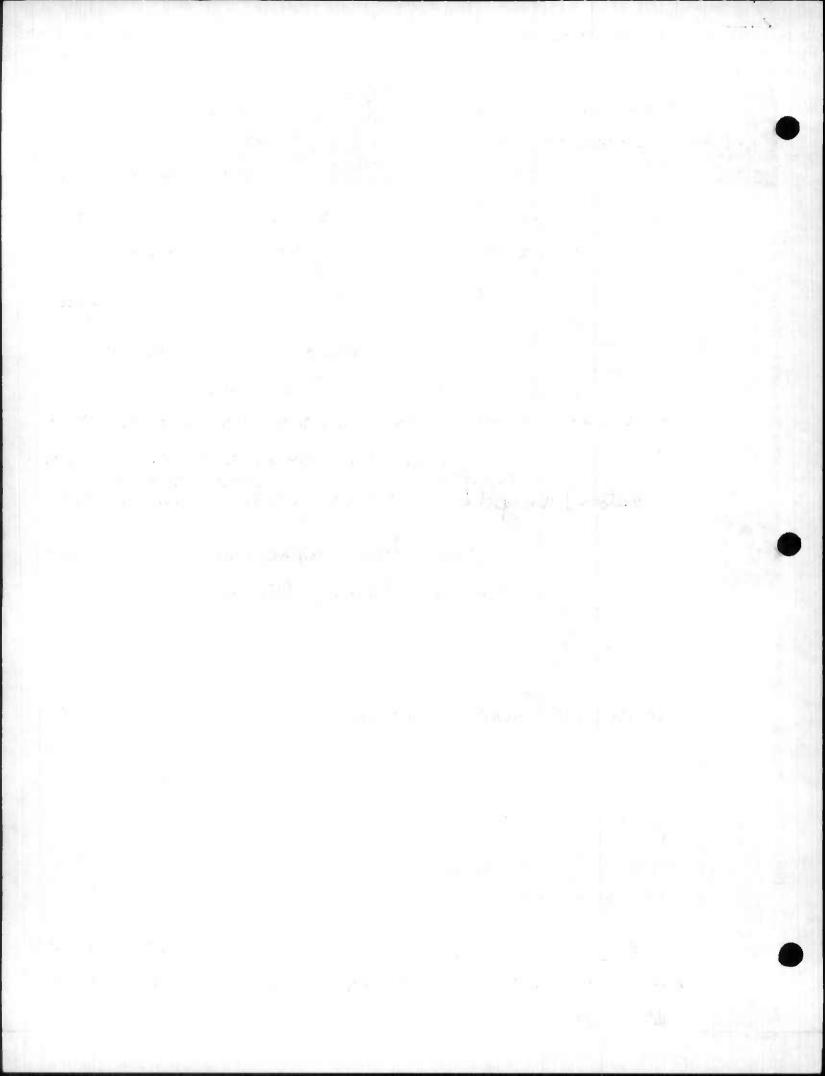
30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

ANN MECHERIKUNNEL

5601, LOCH RAVEN BLUD, BALTO, MD - 21239

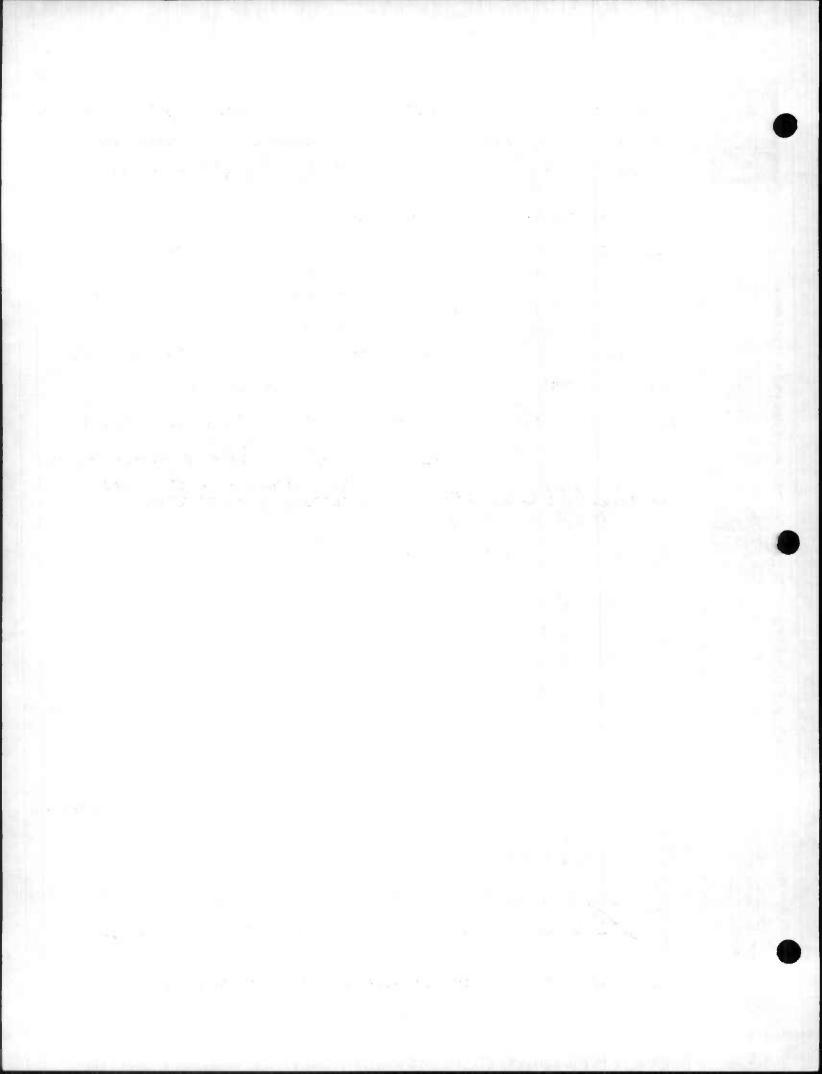
31. Dete filed (Month, Day, Year) State Registrar





		4 December 1 - Franchista 4		inary raina n	Department of Certificate of			Reg. No.	8 07	7296
Physicia /Medic	ai	Decedent's Neme (First, Middle, L. ROBERT 4e. Fecility Neme (If not institution, gi		PA	UL	4b. City. Town. o	2. Dete of De Month March r Location of Deeti	Dey 7, 19	Yeer 98 8	Time of Death 3:25 a.m
Examine Funeral Director	er	Stella Maris 5. Sociel Security Number 6. 218-22-9329	Hospice	Age (In yrs. lest bii 70	Athdey) It Under 1 Yee Months Dey	TOWSO	n s. 8. Date of Bir	Balt	imore	(Stete or Foreign
show	_	Usual Residence of Decedent		10c. City, Tow						nside City Limits
netural', or items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	MD Baltin 10e. Street end Number 2926 Wells Av		Ed	gemere 10f. Zip Code 21	219		10g. Citizen ot V		I∐ Yes 24€ No
f Health and Mental Hygiane. Itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Maritel Status 1 Never Married 3 Widowed 4 Divorced	12. Wes Deceder Armed Force: 12 Yes 2 It Yes, Give Year or Dates	s?] No	13. Was Decedent of If Yes, specify Cu		Specify Yes or No irto Rican, etc.)		e - American Inck, White, etc. v: White	
Hygiane. oth than "naturent, the Medical	Completed	15. Decadent's E (Specify only highest gr Elementary/Secondery (0-12) 1 2	ducation ede completed) College (1-40	16e	Decedent's Usual Occ (Give kind of work don life. DO NOT use retii Chinist	upetion e during most of w red)	orking	16b. Kind ot B	- Stee	
Mental Hy arked othe atic event	To Be C	17. Fether's Neme (First, Middle, Las Oliver S. Pau	•				eme (First, Middle, e Donto		ne)	
th and Meni 7 is marked traumatic		19e. Informent's Name/Reletionship Erma Paul /	(Type, Print) Wife		. Mailing Address (Street 2926 Well		Rurel Route Numb	-		
0=5		20e. Method of Disposition 1 Burial 2 Cremetion 3 [4 Donatlon 5 Other (Speci	Removel from Stat	20b. Plece o camere	t Disposition (Neme of ny, cremetory or other p Cremato	(ece)	Mar. 9	20c. Location		Stete
Departmar important: any Injury once.		21. Signeture of Funeral Service Lice		10./	22. Name end Add Connell	ress ot Fecility	al Home	of Du	ndalk	, 110
physicia ss tha bur	/Medical Examiner	disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest	b	Due to (or es e	consequence of):	1 a				
led by the attending I deteched for use es	Physician/M	Pert II. Other eignificant conditions	contributing to deeth	but not resulting in	n the underlying cause of	given in Pert I.	23b. Dld	tobacco uae co	ntribute to the	cause of death
bed d	Completed by Ph						24e. Wes	Yes 2 No	24b. Were e	utopsy tindings le prior to tion of cause
cata has							10	Yes ZXXX		s 2 No
h. Aftar this co funeral dire	ation: To Be	25. Wes case reterred to medical examiner? 1 Yes 22040 27. Menner of Deeth 1 Matural 5 Pending investigation	Hospitel: 1 Inpe	jury 28b.	Time of 28c. Inj		eath (Check only of Home 5 Residence 128d. Describe			OSPICE
within 24 hours efter death To the Funeral Director: . complately filled in by tha	Certification:	3 Suicide 6 Could not be determined	286. Piece of I	njury - At home, ta etc. (Specify)	rm, street, tectory, office	9	28t. Location (. City or To	Street end Numb vn, Stete)	per or Rural Rou	ite Number,
within 24 hours effe To the Funeral Dir complately filled in	edicai	29a. Certifier (Check only one) (Check only one) (Check only one)	nysicien: To the bes miner: On the basis end menner:	ot examinetion en	e, deeth occurred et the d/or Investigetion, in my	opinion, deeth occ	curred et the time,	cause(s) end me date end plece,	enner es steted and due to the	ceuse(s)
Vaithii Somp	M	29b. Signature angliturol course	de a	2	29c. Lice	pee number	56	29d. Dete signe	d (Month, Dey,	Year)
25		30. Neme end eddress ot person who DR • EDDIE NAKE			(Type, Print) VALLEY RD	. TIMONI	UM, MD 2	1093		
Stat Registra		31. Date tiled (Month, Day, Year) MAR 0 9 19	32. Renis	rer's Signeture	- Randelle					

DHMH 16 Rev 6/95



					_	artment of ertificate of			Reg. No. 98	07297
ysician		. Decedent's Neme (First, Middle, Las	st)					2. Date of De	eeth Dey Ye	3. Time of Death
Medical			rez					MARCH	1 2 190	18 5:33 PM
aminer	4	e. Fecility Name (If not institution, give		*			4b. City, Town, or	Location of Deal		
	4	Doctors Communit	-			Milhadan d Masa	Lanham	-		Georges
eral ctor	5	. Sociel Security Number 6. Sr 054-22-5997		Age (In yrs. le 68	st birthday Yrs.	Months Deys		. (Month, De		Birthplace (State or Foreign Country) nknown
	-	Usuel Residence of Decedent Oa. Stete 10b. County		10a Cibe	Town and					1
fied at		Maryland Prince	Georges	-	Town or L itol	Heights				10d. Inside City Limits 1 ☐ Yes 2X No
at he notified al Director	1	0e. Street end Number 1109 Adeline Way				10f. Zip Code 20743			10g. Citizen of What	Country?
Examiner must be notified at by Funeral Director		1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Wes Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates] No	. 13. wn	Was Decedent of If Yes, specify Cub		Specify Yes or No to Rican, etc.)	o- 14. Race - A Bleck, W Specify: B	merican Indien, thite, etc. 1ack
rt, the Medical		15. Decedent's Ed (Specify only highest grade Elementary/Secondery (0-12)	lucation de completed) College (1-4o	r 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wo ed)	nrking	18b. Kind of Busine	ss/Industry
			unknown		unkn	own			unknown	
To Be		7. Father's Name (First, Middle, Last) unknown					18. Mother's Na		, Maiden Sumeme)	
the P		9a. Informant's Name/Reletionship (7	Type, Print)		19b. Mail	ing Address (Stree			per, City or Town, State	e. Zip Code)
er tra		unknown				nown			,,,	-, -, -, -, -, -, -, -, -, -, -, -, -, -
ry or oth	2	Oa. Method of Disposition 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	e car	ca of Disp netery, cre	osition (Name of metory or other ple	900)	Date	20c. Location - City	or Town, Stete
any injury once.	2	11. Signature of Funeral Service Licans Joseph B. Va	see	ent.	- 2	2. Name end Addre State An Baltimor	ess of Fecility atomy Boa	ard, 655	W. Baltin	nore Street
	1	Part Enter the disease, or comp shock, or heart feilure. List only	olicetions that cause	ed the deeth.	Do not en					Approximate Interval Between Onset and Death
ian ical ner	1	mmadiate Cause (Final isease or condition esulting in death)	. IRREVE	RSIBI	EC	B AMO	BRAIN		+1	Onset and Death 24 HOUR
alt liner			EXTENS	Due to (or e	BAS	The second second	BUA H	REMORE	THAGE	36 HOURS
butal-transit	100	equentially list conditions, any, leading to immediate ause. Enter Underlying	111/00	Due to (or a	s a conse	quence of):	710001	1100	VSCMOF	10 1/000
etached for use as the bur Physician/Medical	100	aube (Deease or injury nat inflated events esulting in death) Last	d.	Due to (or e	s a consec	QUERECKI	OVASCU	UK L	DISEASE	10 YEARS
oler u	L									
0 -		art II. Other eignificent conditions co	intributing to death	but not result	ing in the u	inderlying cause gi	ven in Pert i.		1	Probably 4 Unknown
should leted	_								en eutopsy 24 ormed?	b. Were eutopsy findings evalleble prior to completion of cause of deeth?
Comp								10	Yes 2000	1 ☐ Yes 2 ☐ No
· IO	2	5. Was case referred to medical					26. Place of De	ath (Check only o		
5 e		examiner?	Hospitel: 1 Inpat	ienf 2 Ef	R/Outpetie	nt 3 DOA	hor:		idence 8 Other (S	pecify)
		Manner of Deeth	28e. Date of Inj (Month, D	ury əy Year) 2	8b. Time o Injury	Wo	ryet rk?]Yes 2 □ No	28d. Describe	how injury occurred	
To Be	2	5 Pending investigation			a farm at	reet factory office			Street and Number or	Rural Route Number,
n by the tuneral director, rtification: To Be	2		28e. Plece of Ir	njury - At hom tc. <i>(Specify)</i>	e, iaiiii, si	ioot, taotory, omoo		City or To	wn, Siele/	
tilled in by the tuneral director.		2 Accident 3 Suicide 4 Homicide A Certifier Secretifier Secretifier	28e. Plece of Ir building, e	t of my knowle	edge, deat	h occurred et the ti	me, date and place	e, end due to the	ceuse(s) and menner date end plece, end o	es stated. due to the cause(s)
n by the tuneral director, rtification: To Be	2	2 Accident 3 Suicide 4 Homicide Pa. Certifier (Check only 2 Medical Example)	28e. Piece of Ir building, e raician: To the besi	t of my knowle	edge, deat	h occurred et the ti	opinion, death occu	e, end due to the	ceuse(s) and menner	due to the cause(s)
tilled in by the tuneral director.	2	2 Accident 3 Suicide 4 Homicide 9a. Certifier (Check only 2 Medical Examination) 7b. Signature and title of cartifier	28e. Place of Ir building, e relcian: To the besiner: On the basis end manner s	t of my knowle of examination teled.	edge, deat n end/or In	h occurred et the ti vestigation, in my o	opinion, death occu	e, end due to the	ceuse(s) and menner date end plece, end o	due to the cause(s)
tilled in by the tuneral director.	2	2 Accident 3 Suicide 4 Homicide 9a. Certifier (Check only one) 2 Medical Exami	28e. Place of Ir building, e relcian: To the besiner: On the basis end manner s	t of my knowle of examination teled.	edge, deat n end/or In	h occurred et the tivestigation, in my o	popinion, death occurse number	e, end due to the urred et the time,	ceuse(s) and menner date end plece, end o	onth, Dey, Yeer)

State of Maryland / Department of Health and Mental Hygiene ()

		Decedant's Nama (First, Middla,	Last)		Cer	tificate of	Death	2. Date of Da	Reg. No.	3 17	me of Death
hysician		Claude	Reed					Month	Dey	aax 11	om
/Medical Examiner		4a. Facility Name (# not institution.	giva street and number,	Hose	ortal		Ab City, Town, o	r Location of Deat	1	of Death	-1-1-
Funeral Director		5. Sociel Security Number 215-58-6285	5. Sex 7. Ag 1 ☑ M 2 ☐ F 4	ge (In yrs. la	st birthday) Yrs.	If Under 1 Yea Months Days			rth ay, Year)	9. Birthplaca (S Country) unknown	Stata or Foreig
	- 1	Usual Rasidance of Decedant						200.	17, 1777	GIIICIICIWII	
show ad at		10a. Stata 10b. County	- 4		Town or Loc						lda City Limit ≵Yas 2 □ N
be notified at Director	-	Maryland Baltime	ore City	Bal	timor						ETAS ZUIV
0 M D		2324 Woodbrook	Avenue			10f. Zip Coda 21217			U.S.A.		
Examiner must Examiner must by Funeral		11. Manital Status 1 🙀 Nevar Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant Armed Forces? d 1 ☐ Yes 2 ☐ if Yas, Giva Yaar or Datas:	unkno		/as Decedant of Yes, specify Cul ☐ Yas 2☑ No	Hispanic Origin? (ban, Maxican, Pue o Specify:	Specify Yes or No rto Rican, etc.)		e - Amarican Indick, Whita, atc.	an,
d other than 'natura event, the Medical.' Be Completed		15. Dacadant's (Specify only highest Elemantery/Secondary (0-12) unknown	Education grada complatad) Collega (1-4or unknown	5+)	(Giva k	O NOT use retir	a during most of w	orking	16b. Kind of Bu	usinass/industry	
yent,		17. Fathar's Name (First, Middla, L	ast)				18. Mothar's Na	ame (First, Middle	, Maidan Sumen	na)	
		Roosevelt Arms	rong				unknow	m			
sumatic event, 1 To Be C		19a. tnformant's Name/Ralationsh					et and Number or F				
tem 27 is marke other traumatio To	-	Roosevelt Arms	rong/fathe			aratoga ition (Nama of	Street, E				
repartment of results in them 27 in they injury or other tri		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 🖫 Othar (Specific Actions)		Data	20c. Location -	City or Town, Sta	ate				
any in		21. Signatura of Funeral Sarvica L Joseph B	an Sant	1			ass of Facility fromy Boa , Maryla			nore Str	eet
edical miner		Immediate Cause (Final disease or condition resulting in death)	· LIRR		es a consequ	ranca of):	er				
as the burlat-transit		Sequentially list conditions, if any, leading to immediate gause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с		as a consequ						
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of by the attending stached for use Physician/I	h	Part ti. Other significant condition	a contributing to death b	ut not rasult	ing in tha un	darlylng causa g	ivan In Part I.	23b. Dld	tobacco usa co	ntribute to the ca	uee of death
be detact by Phy								10	Yes 2□No	3 Probably	4 Dunknon
s been s 2 should pleted									an autopsy ormad?	24b. Wara auto avallabta p complation of death?	opsy findings prior to n of cause
page Corr								10	Yas 2000	1 □ Yas	2□ No
Be day		25. Was case referred to medical examiner?						aath (Check only	ona)		
To all dire	-	1□ Yes 2∏ No	Hospitel: 1 Inpatie		R/Outpatlent	3D DOA		Home 5 ☐ Resi			
After fune tion	1	77. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigs 3 ☐ Suicide 6 ☐ Could no	70929	lry Year) 2	8b. Tima of Injury	28c. Inju We M 1[ury at ork?] Yas 2 □ No		how injury occur		
		4 ☐ Homicide determin	28a. Placa of Inj	ury - At hom c. (Spacify)	a, farm, stre	et, factory, office			Street and Numb wn, Steta)	er or Rural Routa	Number,
pletely edica		29a. Certifier 1 StratifyIng (Check only one) 2 Medical E	Phyalcian: To tha best aminer: On tha basis o and mannar st	f axaminatio	edge, deeth n and/or inv	occurred at tha tastigation, in my	ima, data and ptac opinion, daath occ	e, and due to tha curred at tha tima,	causa(s) and ma data and placa,	nnar as steted. and due to the ca	usa(s)
Tou	1	29b. Signatura end titla of cartifiar	hen				9245	5 29d. Data signed (Month, Day, Year) 3/1/98 YERAL HOSPITAL			
	3	0. Nama end addrass of person w	no complated cause of c	leeth (Item 2	(Type, F	Pular	1 Gene	Ral +	Hospit	20	
State	1	31. Data filad (Month, Dey, Yaar)	2 32. Degistr	ar's Sidentu	17 66	MINE	- 01011	, ~~ /	.07		

**** 300 6 0 no.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death **Physician** 50 rederich Kobinson tebruary /Medical 4e. Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location of Deeth , 4c. County of Death **Examiner** Liberty Medical Center Baltimore City Baltimore | | Under 1 Year | If Under 24 Hrs. | | Months | Days | Hours | Min. | 8. Date of Birth (Month, Dey, Year)
March 2, 1952

8. Birthplace (State or Foreign Country)
unknown: 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** 1 № M 2 🗆 F 45 Yrs. 241-82-5176 Director Usuai Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if fam 27 is marked other than "natural", or flams 23s or 28s-f show any injury or other traumatic event, the Medical Eventuel Institute. 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TYes 2 No Maryland Baltimore City Baltimore Directo 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 2614 Park Heights Avenue 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces? unknown

1 yes 2 No
If Yes, Give Race - American Indien, Black, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Never Merried 2 ☐ Married Specify: Black 1 ☐ Yes 2 🛣 No þ lf Yes, Give Yeer or Detes: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be unknown unknown P 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meliing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lena Johnson/sister unknown 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donetion 5 NOther (Specify) 21. Signeture of Funerei Service Licensee
Joseph B Van Sant 22. Name end Address of Fecility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 B. Han 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervai Between Onset end Deeth Physician /Medical immediate Cause (Finei disease or condition resulting in deeth) Examiner Physician/Medical Examiner physician and s the burial-transit law requires that the death certificate be asscuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760, asarca Due to (or es e consequence of) attending pt signed by the a d be detached i Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Unknown 3 Probably 1 Yes 2 No by 24a. Wes en eutopsy performed? 24b. Were autopsy findings evallable prior to completion of cause of deeth? Completed has page 2 1□ Yes 2 No certificate 1 Yes Hospital or Attanding Physician: 25. Wes case referred to medical examiner? Be 28. Piece of Deeth (Check only one) 27. Manner of Deeth
1. Neturel 5
2. Accident Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 5 Pending investigation 24 hours after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end manner es stated.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) end menner stated. Ca 29e. Cartifier To the Hosp within 24 ho To the Fune completaly f (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 4

MC

32. Registrer's Signeture

ulia Davidson

State Registrar Hatez C 31. Dete filed (Month, Dey, Year)

MAR 0 9 1998

901 BB 0

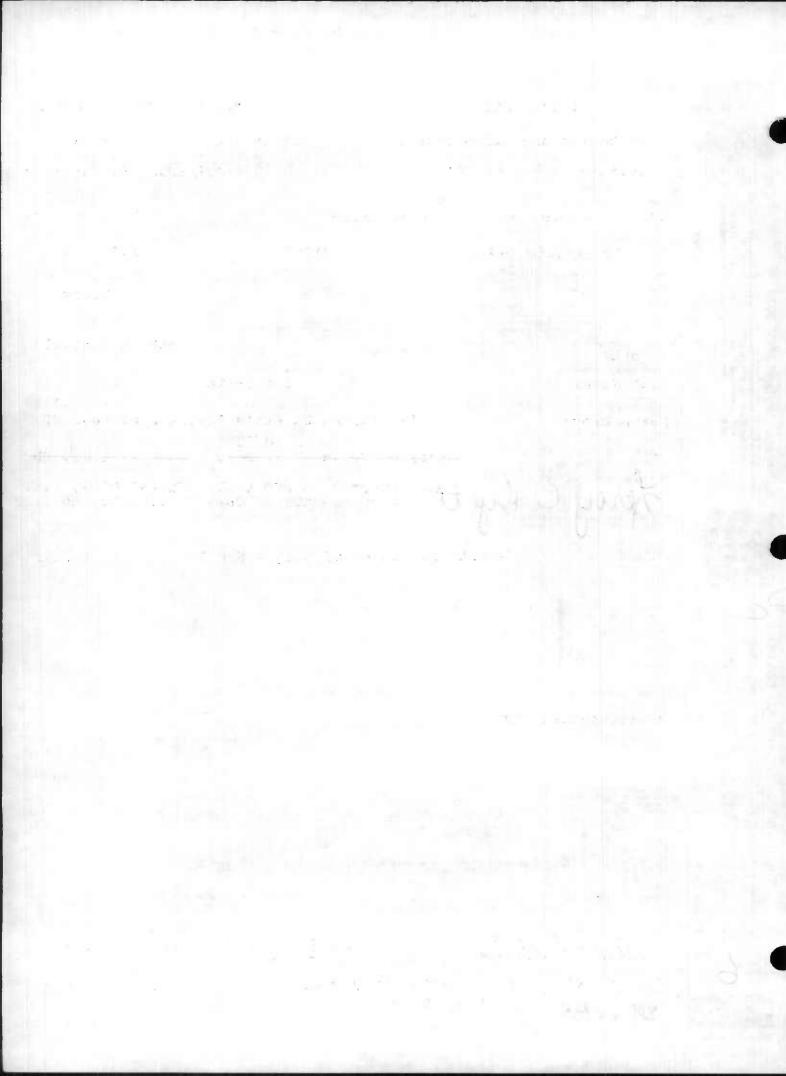
a was had

Items: 20bc Per FH Film G-757 3-9-98RC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 2. Dete of Deeth 1 Decedent's Neme (First Middle Last) MARCH 3, **Physician** 9:50am JAMES SMITH 1998 EDGAR /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner 7204 Chalkstone Drive (res.) Pikesville Baltimore 8. Date of Birth (Month, Day, Year) 05/07/1930 If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign Country)
S. Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours Min 1**™** M 2□ F 67 Yrs. 249-42-3037 **Director** Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-1 show idical Examiner must be notified at MD Baltimore Pikesville 1 ☐ Yes 2 X No Directo 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21208 U.S.A. 7204 Chalkstone Drive death \ Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Maritel Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Haatih and Mental Hygiene.
ant: if item 27 is marked other than "natural; or ite marked other than "natural; or ite winy or other traumatic svent, the Medical Entiting my or other traumatic svent, the Medical Entiting my. I □X/es 2 □ No If Yes, Give Yeer or Detes: 1 Never Married 2K Merried timore, Maryland 21215-0020 1 Yes 2 XNo Specify: Black. py 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Rusiness/Industry Etementery/Secondery (0-12) College (1-4or 5+) Bethlehem Steel Laborer 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Ida Smith Paul Watkins 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21117 19a. Informent's Neme/Reletionship (Type, Print) 112 Enchanted Hills Rd., Reisterstown, MD Karen Brown 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 3/10/98Dete 20c. Location - City or Town, Stete 20e. Method of Disposition important: If ite any injury or oth 1 Buriat 2 Cremetion 3 Removel from Stete Garrison Forest Wings Mills, MD Vet. Cem. 4 Donetion 5 Other (Specify) DYETT LEROY O. δ SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD 21207 ed the death. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximate Intervel Between Onset and Deeth Physician Immediete Ceuse (Finat disease or condition resulting in death) /Medical Metastatic Cancer of Lung - Non Small Cell 1 year Examiner Due to (or es e consequence of) Examine physician and the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. certificate be Physician/Medical Due to (or es e consequence of): use as t 23b. Did tobacco usa contributa to the causa of death? ed by the a Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. signed by N Yes 2 No 3 Probably 4 Unknown Myelophthisic Anemia Records, þ 24b. Were autopsy findings available prior to should b 24e. Wes an eutopsy performed? Completed completion of cause of deeth? certificata has b irector, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital 25. Wes case referred to medical exeminer? Be 26. Ptece of Deeth (Check only one) To Other: 4 ☐ Nursing Home 5 ☐ Nesidence 6 ☐ Other (Specify) 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28d. Describe how injury occurred 28b. Time of 27 Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? After ! Certification: Hospital or Attending 1 XNeturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident aftar death 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. edical completaly 2 Madical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) To the To the 29d. Date signed (Month, Dey, Year) 29b. Signature and little of offilier March 4, 1998

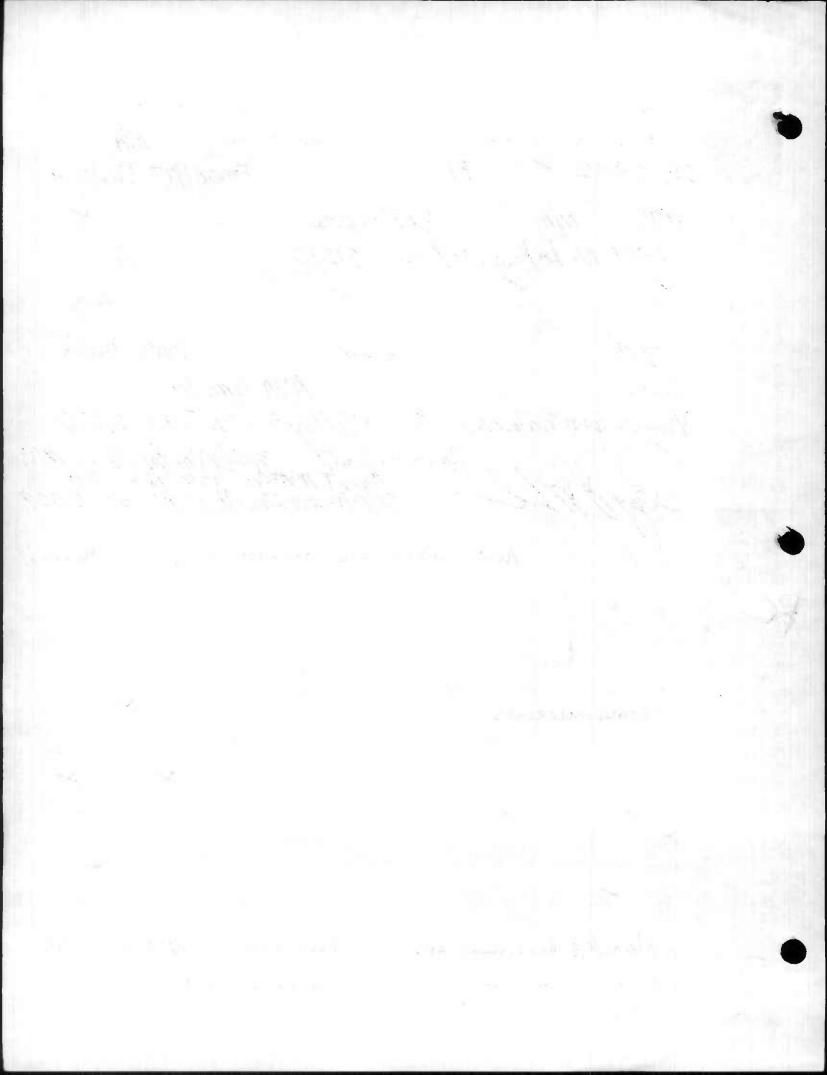
W. Belve Leve Ave BaltimoreMD21215

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rolent Role M 243 1 N.



							of Death		leg. No.		
PI	nysicia	in	1. Decedent's Nama (First, Middle, Las	51)	6 3	er mar		2. Date of Dea Month MARCH	-	998	3. Time of Death
	Medica	al	RUSSELL		SI	HTIM	41 Ch Taum and		,	Live of F	22:20PM
E	xamine	er	4a. Facility Name (If not institution, give THE JOHNS HOPKINS				4b. City, Town, or L BALTIMORE		4c. County	A //A	
5	1		5. Social Security Number 6. Se		(In yrs. last birthda	If Under 1 Y			1	9 Rirthol	aca (State or Foreign
Dire	neral ector			2 F	8/ Yrs.		ays Hours Min.	8. Dale of Birth Month, Day	39917	VIR	GINIA
aryland	dat	_	10a. State 10b. County	10	10c. City, Town or	Location		-		10	od. Inside City Limits
the Marylar	elle	Director	ITY, NI	A	DA	HIMO	15-				
with	The contract of	ā	10e. Street and Number	a Variant	A ALK	10f. Zip Cod	2013		log. Citizen of	S A	try?
Seath		Funeral	11. Marilal Status	12. Was Decedeni Ev	ver in U.S. 13	3. Was Decedent	of Hispanic Origin? (St	pecify Yas or No-	(1)	e - Amarica	an Indian.
d 21215-0020 filed within 72 hours after death with the Maryland thygiene.	- National	þ	1 2 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify to	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Spacity:	Ricen, etc.)	Blac Specifi	ck, White,	
15-002 72 hours		Completed	15. Decedent's Ed (Specify only highest grad	lucation	16a. Dec	cedant's Usual Oc	ccupation	kina	16b. Kind of B	usiness/Ind	lustry
21215-0020 d within 72 hours af		mpie	Elementary/Secondary (0-12)	College (1-4or 5+	life	DO NOT use re	one during most of work atired)	, ing	1200	= 7	zank/
d 212 filed with Hygiene.	if,		17. Fathar's Nama (First, Middle, Last)			GYOUN	18. Mother's Nam	o (First Middle	Maiden Sumer	2 //	XVC)
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2 should and Men	T I	2	19a, Informant's Name/Relationship (7	Type, Print)	19b. Ma	niling Addrass (St	reet and Number or Ru	ra i Routa Numbe	r. City or Town	State Zio	Code)
	rtrac		Vipan 15- Forms	BATEMAN	1 72	337	7/1/2019	T. BOI	T. Mg	2 23	230
P - I	othe		20a. Method of Disposition	11/04/04/	20b. Place of Dis	position (Name o	injeco)	Date	20c. Location	City or To	wn, State
Pegas Pent of	ر ر		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		Carron 40	n-France	57	3/12/999	Zon No	1/5/11/	un Mi
Baltimore, N pemit. Pegas 1 and Department of Health	/ injury	1	21. Signature of Femeral Seavice License	100//	CATTO	22. Name and A	defens of The The	A FILM	Ral A	moz	DA
n 888	any ir		Van 9 81			17/12	12×4281.17	in Pass	93017	TWI	17 1 22 29
			23a. Parti Enter III and and or or no shock, or hand failura. List only of	plications that caused to	he death. Do not e	enter the mode of	dylng, such as cardiac	or respiratory arr	est,	1///	Approximate Interval Batween
Physi	cian		Shook, of Heath failura. List only t	one causa on aach ima						1	Onset and Death
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	-	9	resulting In daath)		oue to (or as a cons		INFAR	CTION			16 hours
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	the bur	ledicai Examiner	Sequentially list conditions, if any, leading to immediata ceuse. Entar Underlying Cause (Disease or Injury that initiated evants resulting in death) Last	b	oue to (or as a cons	sequence of):	_ INFAR	CTION			16 hours
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State of Maryland / Department of Health and Mental Hygiene 17.3.0.2

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Physic /Medi		1. Decedent's Neme (First, Middla, L				Silve				Date of Dee Month	Dey 7	Yeer 98	3. Time of Death 1143 A
Examir	ner	4a. Facility Name (If not institution, g WIVES IN OF M 5. Social Security Number 6.	aylord				2	Bald If Under 24	hme	ore	691	nno	
uneral irector		217-40-6358 Usuel Residence of Decedent	10 X M 2□ F	53	Yrs.	Months	Days		Min.	Deta of Birt (Month, De 10-9-	, Year) 1944	Coun	lace (Stete or Foreig htry) MD
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s 23a or 2		10e. Street end Number 1223 OSTEND ST					1230				10g. Citizen of U.S.	۹.	
natural, or mem	by Funeral	11. Maritel Status 1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorcad	12. Was Dece Armed Fo 1 Tes If Yes, Giv Yaer or Da	2√ No		Wes Decedi If Yes, spec 1 ☐ Yas 2		ispanIc Origin on, Mexican, I Specify:	1? (Specify Puerto Rica	Yas or No- an, etc.)		ca - Americ ck, Whita, ^{'y:} AFR.	
the Medical	Completed	15. Decedent's (Spacify only highest g Elementery/Secondery (0-12) 12	Education reda completed) College (1	-4or 5+)	(Giva	dent's Usue kind of wor DO NOT us ABORE	k done d e retired	etion during most o	f working		16b. Kind of B	usiness/Ind	
markad other matic event, I	To Be C	17. Fether's Name (First, Middle, Last) WILLIE SILVER 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Stree									Meiden Sumer	ne)	
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within 2 To the comple		> m cursh	~oda		physic			606				1 1 9	

m. Christine Lawson Limins (stock hours bettinore, no

State Registrar

31. Dete filed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

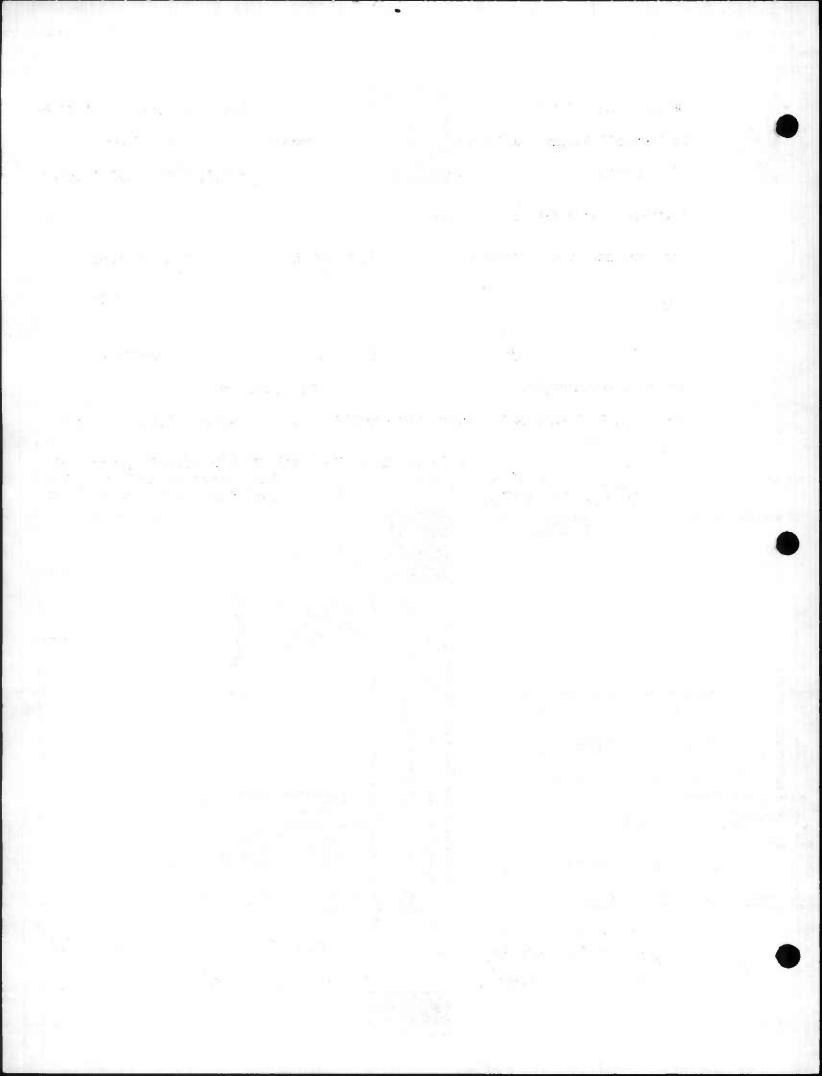
32. Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene

f Health and Mental Hygiene 98 07303

						Ce	rtificat	e of i	Death		R	eg. No.	U	0/3(10
			1. Decedent's Name (First, Middle, Last	")							2. Dete of Dee	th		3. Time of	Death
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	Examili	iei	Pickersgill Retire						_						
_			5. Sociel Security Number 6. Se		7. Age (In yrs.	la et hirthrlau	If Under	1 Year	TOWS		8. Dete of Birth		timore		Carrier
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and		Be	17. Father's Neme (First, Middle, Last)							r's Name	(First, Middle, I				
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Mary	should ind Men in marks umartic	_	19e. Informent's Neme/Reletionship (T)			19b. Meili	ng Address	(Street			I Route Number	City or Town	, Stete, Zic	Code)	
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(10	10	30. Neme end address of person who	mpleted cause			Print)	10	1.0		t. Ba	01.	111	3.34	
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State of Maryland / Department of Health and Mental Hygiene 98 07201

HI	FFLETT SF	₹.	Otato of Mar	Ce	ertificate of	Death	R	eg. No.	0 1	304
	Physician			Hammer	Shifflett	, Sr.	2. Data of Dear Month MARCH (Day	Yaar	Time of Death
	/Medical Examiner	An Cantilla, Marine of the state the state of the state o				4b. City, Town, or DUNDA	Location of Death	4c. County	of Death	.VVJ A
	Funeral Director		Sex 7. Aga (In yrs. last birthday 89 Yrs.) If Under 1 Yaar Months Days	If Under 24 Hrs Hours Min		Year)		(Stata or Foraign
	D	Usual Residence of Decedent 10a. Stata 10b. County Maryland B	altimore	Oc. City, Town or L		nđalk				Inside City Limits
	th with the Mer 23a or 28a-1 s at be rotted		oad		10f. Zip Code 21	222	1	Og. Citizen of V	What Country?	
020	72 hours efter deeth with the Meryland natural; or items 23s or 28s-f show dical Examiner must be notified an eted by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedant Eve Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Dates:	er in U.S. 13	. Was Decedant of H If Yes, specify Cub 1 ☐ Yas 2 ☒ No		Specify Yes or No- to Rican, etc.)		e - Amarican I ck, White, etc.	
21215-0020	ygiena. ygiena. ver than "natura rt, the Medical E	15. Decedent's (Specify only highast g		(Giv	edent's Usual Occup a kind of work dona DO NOT use retire	during most of wa	rking	16b. Kind of Bu		
	be filed within stal Hygiena. d other than event, the He	11 Years 17. Fathar's Nama (First, Middla, Las		W	elder		me (First, Middle,		Indus	try
Maryland	2 should be and Ment Is marked summites	Sandy Warren Sh 19a. Informant's Name/Relationship	(Type, Print)		ling Address (Street	and Number or R			Stata, Zip Co	
altimore, N	permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Merylen Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show mithoritant: if item 27 is marked other than "natural", or items 23a or 28a-f show mithority or other traumatic event, the Medical Examiner must be notified and not highly or other traumatic event, the Medical Examiner must be notified.	Elbert Shifflet 20a. Method of Disposition 1 Bunial 2 Cramation 3 4 Donation 5 Other (Spec	☐Removal from State	20b. Place of Disp cematary, cr	O Ormand consition (Nama of amatory or other plants m Cemeter	ce)		20c. Location -	City or Town,	
Baltir	Departme Departme Importan any Injur	21. Signature of Forerai Service Lice			22. Name and Addre Duda-Ruck 7922 Wise	ss of Facility Funeral	Home of	Dunda1	k, Inc	•
	Physician /Medical Examiner	21a Fant: Enter the defining or co- shock or heart follow. List on Immediate Cause (Final disaasa or condition resulting in death)	Center	e death. Do not e	four Us	ng, such as cerdia		est,	Ap Int Or	proximate erval Between iset and Death
x 68760,	ertificate be executed ing physician and e es the burist-transit		C	e to (or as a conse						
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Vital Re	ician: The law certificate has be rector, page 2 s	25. Was cese referred to medical				26. Place of De	ath (Check only or	es 2 No	100	as 2 No
Division of Vi	or Attending Physical death. Director: After this In by the funeral dispers	1 No 2 No	be 32- Disco 415	- At home, tarm,	of 28c. Inju Wo	ner: 4 Nursing	28d. Describe h 28f. Location (6 City or Tow	ence 6 Oth ow Injury occur at and Number	lotse,	A guite Number Clay Rose
	o the Hospital rithin 24 hours of the Funeral on the Funeral ompietaly filled Medical Ce		thysician: To the best of numiner: On the basis of exemples and manner states	amination and/or i	th occurred at the tinvestigation, in my	me, date and place	e, and due to the durred at the time, d	ause(s) and malate and place,	anner as state	d. e cause(s)
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State Registrar

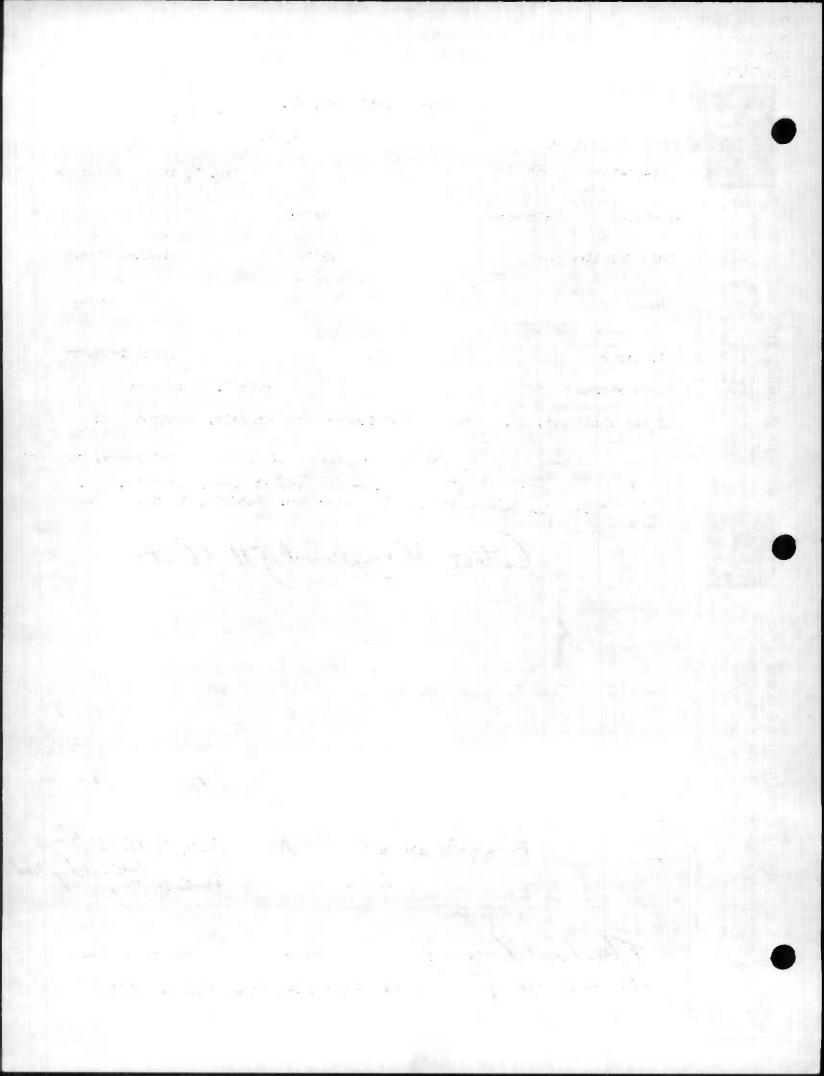
THEODORE MIKING 31. Data filed (Month, Day, Year) MAR 0 9 1998

111 Penn Street, Baltimore, Maryland 21201

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MARCH 04, 1998

Meadow MI And Supplemental August (Type, Print)



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month 03 **Physician** NELLIE COONS SHAFER 7:50PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Frederick Frederick Homewood of Frederick 7. Aga (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 20 F Yrs. 84 219-20-3477 **Director** Pennsylvania 05 - 23 - 13Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Evanturer must be published at another. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 U.S.A. 31 West Patrick Street Funeral Was Decedent of Hispanic Origin? (Specify Yas or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: Baltimore, Maryland 21215-0020 1□Yas 2□No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Collega (1-4or 5+) Supervisor Federal Government 10 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Sumame) John Ellsworth Coons Laura Rebecca Boyles 19a, Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) Sue Masser/daughter 7750 A. Kemp Lane, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensaa Joseph B. Van 22. Nama and Addrass of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a Part 1 Ehtar tha diseasa, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona causa on aach lina. Interval Between Onsat and Death Physician CARDIAC /Medical Immediate Cause (Final ARRYTHMIA disease or condition resulting in death) lician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): physician the buria Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) -990 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by DIABETES 1 Yes 2 No 3 Probably 4 Unknown MECLITUS ğ 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy periormed? HYPOTHYRUIDISM Pass Pass page 2 1 ☐ Yes 2 ☐ No 1 □ Yes 2 □ No certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica 25. Was casa referred to medical examiner? Be 26. Placa of Death (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28b. Tima of 28c. injury at Work? 5 Pending invastigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Cartifian 1 👺 Certifying Physician: To the best of my knowledga, daath occurred et the time, date and placa, end due to the causa(s) end mannar as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. To the within 2 To the 29b. Signatury 29c. License number 29d. Dete signed (Month, Day, Year) D34303 03-02-98 ddress of person who complated causa of death (Itam 23a) (Type, Print)

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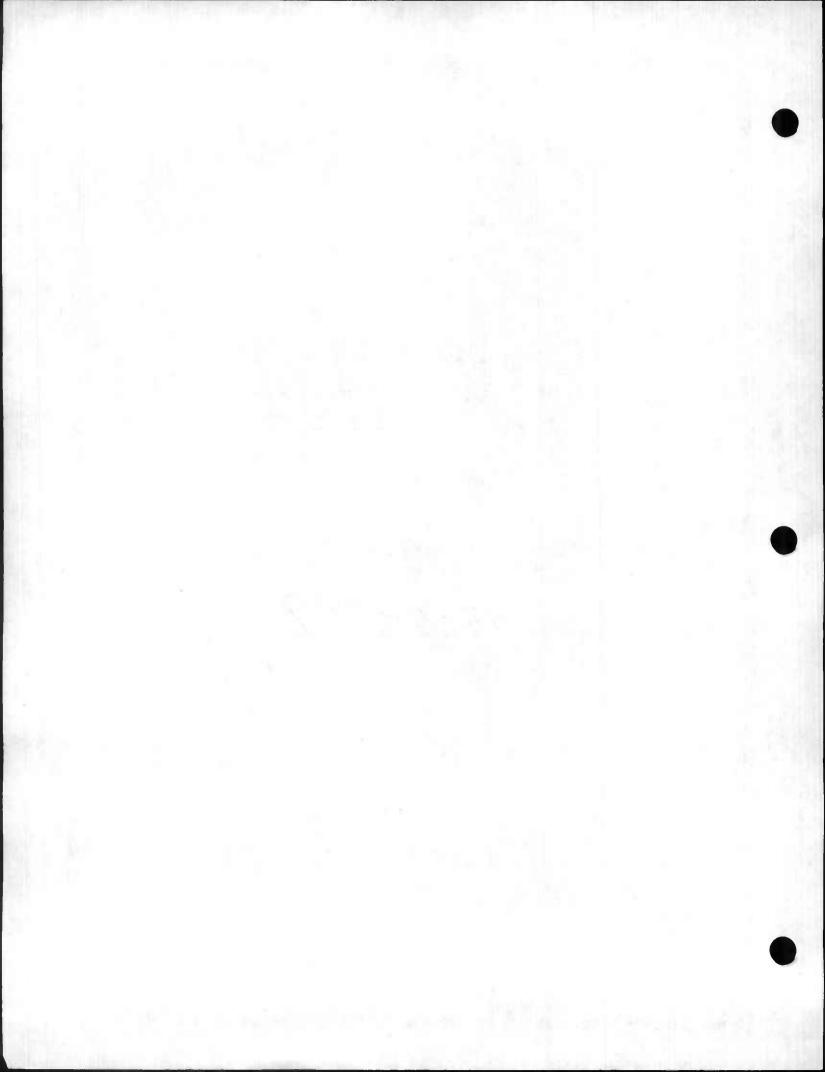
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Physici					Certificate		nental Hygi	g. No.	8 0730
40.00 40		Decedant's Name (First, Middla, Last	Cody	Lee	Trumps		2. Dete of Deeth Month March 1		3. Time of Dear 9:30 P
/Media		4e. Fecllity Neme (If not institution, give	street and number)			4b. City, Town, or L		4c. County of	
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Funeral Director		5. Social Security Number 6. Se none 10 Usual Rasidance of Decedant	XM 2DE	a (In yrs. last b		eer If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, Feb. 28	(ear) ,1998	9. Birthplace (Stata or For Country) Maryland
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23a or 28 ast be not	ai Director	10e. Street end Number 6702 Shakerwood	Road		10f. Zip Co	da 212:		g. Citizen of Wh United	at Country? States
"natural", or itema 23a or 28a-f show adicai Examiner must be notified st	by Funeral	11. Maritel Status **M2Nevar Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forcas? 1 Yes 2 IX		13. Was Decedant If Yas, specify	of Hispenic Origin? (Sp Cuban, Maxican, Puerto No Specify:	ecify Yas or No- Rican, atc.)		American Indien, White, etc.
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nd Mental Hygi marked other mattic event, t	To Be C	17. Fathar's Nama (First, Middla, Last) George Trumps					a (First, Middle, M arie Clar		
2 - 2		19a. Informant's Name/Ralationship (7) Mr. George Trumps			b. Mailing Addrass (Si 702 Shakery	reet and Number or Ru Nood Road	al Route Number, Baltimore		
Department of Health a Important: If Item 27 Is any injury or other tra once.		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ F 4 ☐ Donation 5 ☐ Othar (Specify)	lamovel from State	cemat	of Disposition (Nama of ary, crematory or other top Service	place)	Data 2	oc. Location - C	ity or Town, Steta
Departra Importa any inja once.		21. Signature of Finaral Sarvice Licens	500)_	Duda-Ru	ddress of Fecility ck Funeral	Home of		
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by the a	Physician/Med	Pert II. Other significant conditions con		ut not rasulting	in tha undarlying ceus	a givan In Part I.	23b. Did tob	1	ibute to the cause of de
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month SELENE LYNN February 23, 1998 /Medical 4e. Facility Neme (If not Institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 7 Quacker Court Sparks Baltimore 5. Sociel Security Number If Under 1 Months I Year If Under 24 Hrs. Days Hours Min. 7. Age (In yrs. last birthdey) Birthpiece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1□M 200F Days 217-48-2210 50 Yrs. Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if Item 27 is marked other than "natural", or ferms 23s and many injury or other traumatic event, the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other traumatic event of the Maryland other event of the Maryland other event of the Maryland other event of 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Sparks 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7 Quacker Court 21152 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 € Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coitege (1-4or 5+) 12 Financial Planner unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Edmund Tileston Mudge III Mary Lynn Brett Marburg 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ashley Schultz/daughter 621 West Nickerson Street, Seattle, Washington 98119 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses Sant Joseph B. ²²State Anstolly Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician /Medical Immediate Cause (Finel OVARIAN CANCER disease or condition resulting In deeth) Examiner Examiner physician end the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of): been signed by the atter should be detached for a Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? 2 (No 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 1 Yes 2 VA 28c. Injury et Work? 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: Attending P er death. 1 Neturel 2 Accident 5 Pending 1 Yes 2 No Investigation or Attand efter death Director: 8 Could not be determined To the Hospital or Atta within 24 hours efter de To the Funeral Directo completely filled in by th 3 ☐ Sulcide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner es stated.

2 Medicat Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piace, and due to the cause(s) end menner stated. edicai 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

GARY CONEN, MD 6569 N. WALLES ST. BHITIMONE, AND

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** March 7, Milada Vanicek 1998 7:15 am /Medical 4b. City. Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Franklin Square Hospital Center Rosedale Baltimore If Under 1 Yeer | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Yeer) Deys Hours 1□ M 200 X Yrs 132-44-7076 February 14 1929 69 Republic Usual Residence of Decedent FEBRUARY 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes XX No Directo **Baltimore** County Parkville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3810 Walther Blvd. 21234 USA 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Yes 200 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White py 3 X Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Teacher Education Uhknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Anthony Mrazek 2 Anna Unknown 19e. Informent's Name/Retetionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Rena Vanicek 7046 Greenbank Road, Baltimore, MD 21220 20b. Plece of Disposition (Neme of cemetery, cremetory or other place)
Netro Cremetory Dete 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) March 9 1998 Catonsville, Maryland 21. Signature of Funeral Service License 22. Name end Address of Fecility Slack Funeral Home, P.A. MUU535 Filicott City, Maryland 21043.

The complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory one cause on each line. Approximete Intervel Between Onset and Deeth immediete Ceuse (Finel disease or condition resulting in deeth) a Ischemic Stroke 24 weeks Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iritilated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation , Hypertension þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy Completed 2 0 No 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes at No 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Dete of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? Natural 5 Pending investigation 1 Yes 2 No 2 [] Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3/1 Suinide Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical Certifying Physician 29a, Certifie To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as steted. On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) and menner stated. /Check only cess) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dey, Year) ACKERMANN, DO RD2113

Baltimore, Md. 21237

within 24 hours of To the Funeral

State Registrar

31. Date filed (Month, Day, Year)

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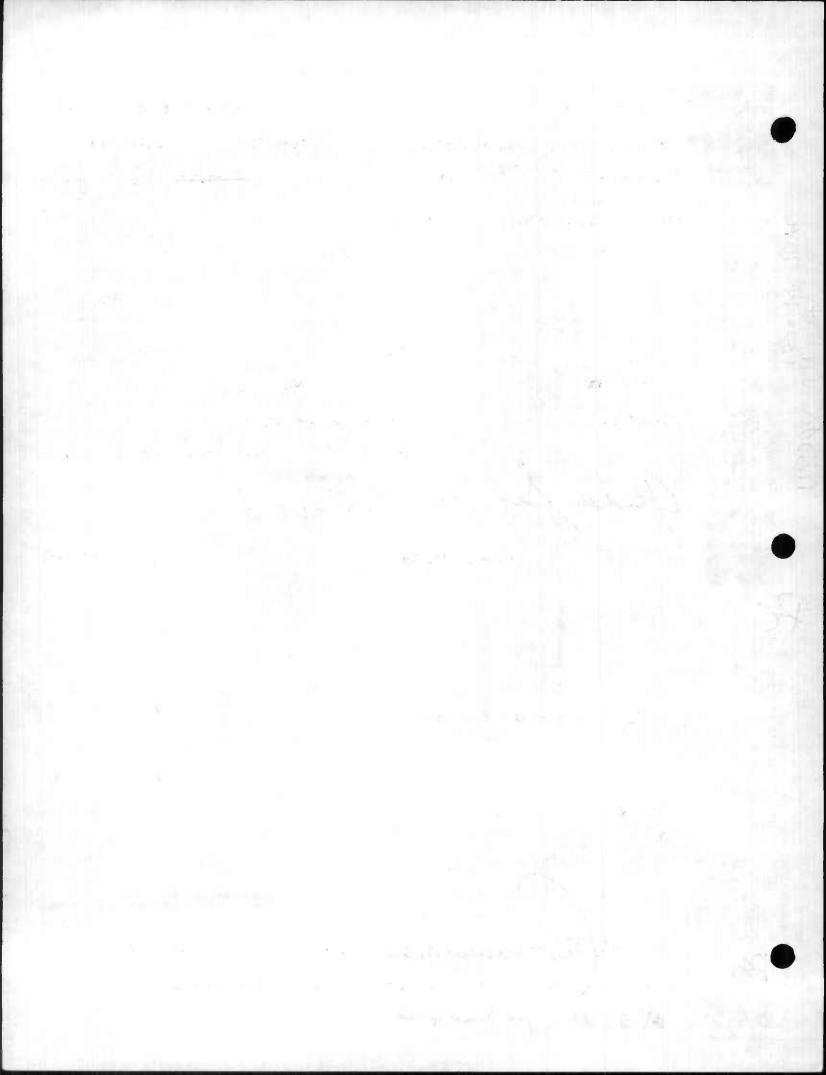
M.D

30. Name and address of person w

Alan

9000 Franklin Square Dr. 32. Registrer's Signeture wienderickon Randelle

completed cause of deeth (Item 23e) (Typa, Print)



Please Type or Print in Black Indeible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Year Millard В. Weese 1998 6 10:00 AM March 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2748 Kirkleigh Rd Dundalk Baltimore If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Undar 1 Yaar 7. Aga (In vrs. last birthday) Birthplaca (State or Foreign Country) 1X M 2□ F Months Days 75 234-26-0126 March 9 1922 W. VA Usual Residence of Decedent 10a State 10c City Town or Location 10b County 10d Inside City Limits 1 ☐ Yes 2 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2748 Kirkleigh Rd 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 1 1 Yes 2 □ No If Yas, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Navar Married 2 ☐ Married 1 Yes 2 No Specify: Specify. 3 ₩ Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Welder Auto Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Lemon Weese Bessie McCoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Walter /daughter 401 Acadia Drive Joppa, MD 21085 20b. Place of Disposition (Name of cametary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Mar. 9 1 ⊠Burlal 2 □ Cremation 3 □ Removal from State 1998 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk emelle 7110 Sollers Point Rd 23a. Part1. Enter the disease, or complications that caused the defin. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellight. List only one cause on each line. Approximete Intarval Between Onset and Death Immediate Cause (Final . SUDDAN CARDIAC disease or condition resulting in death) Due to (or as a consequence of) ISCIRMIC CARDIO MY Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cousa (Disease or injury that initieted events resulting in deeth) Lest Due to (or as a consequence of) MOXIAMY Due to (or as a consequence of) 10.18P18 VASCIRAN ATHUO SCIEROTIC Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Wes an eutopsy 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home Shesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Neturel 2 Accident 5 Pending Investigation 1 Yes 2 No 3 Suicida 6 Could not be

Examiner attanding physician and for use as the buriel-trensit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the ai by should I Completed s certificate has l director, page 2 s director, Be 10 funeral Certification:

Physician /Medical

Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be liled within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be not an abose.

altimore, Maryland 21215-0020

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by th

State Registrar

edical

30. Name and add 31. Date filed (Month, Day, Year)

MAR 0 9 1998

4 Homicide

29b. Signature and title

29a. Certifier (Check only one)

MC

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

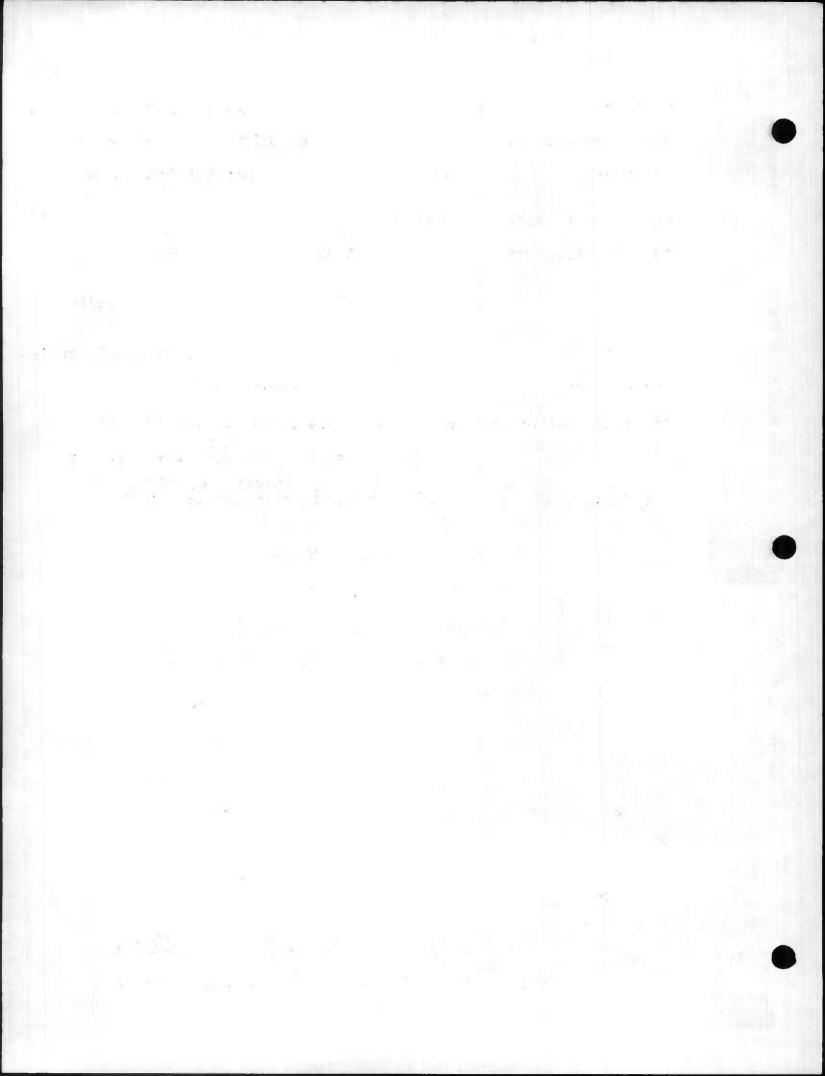
ess of person who completed cause of death (Item 23a) (Type, Print)

1 8 5 7 4940 6 7 57 W

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

who Davidson

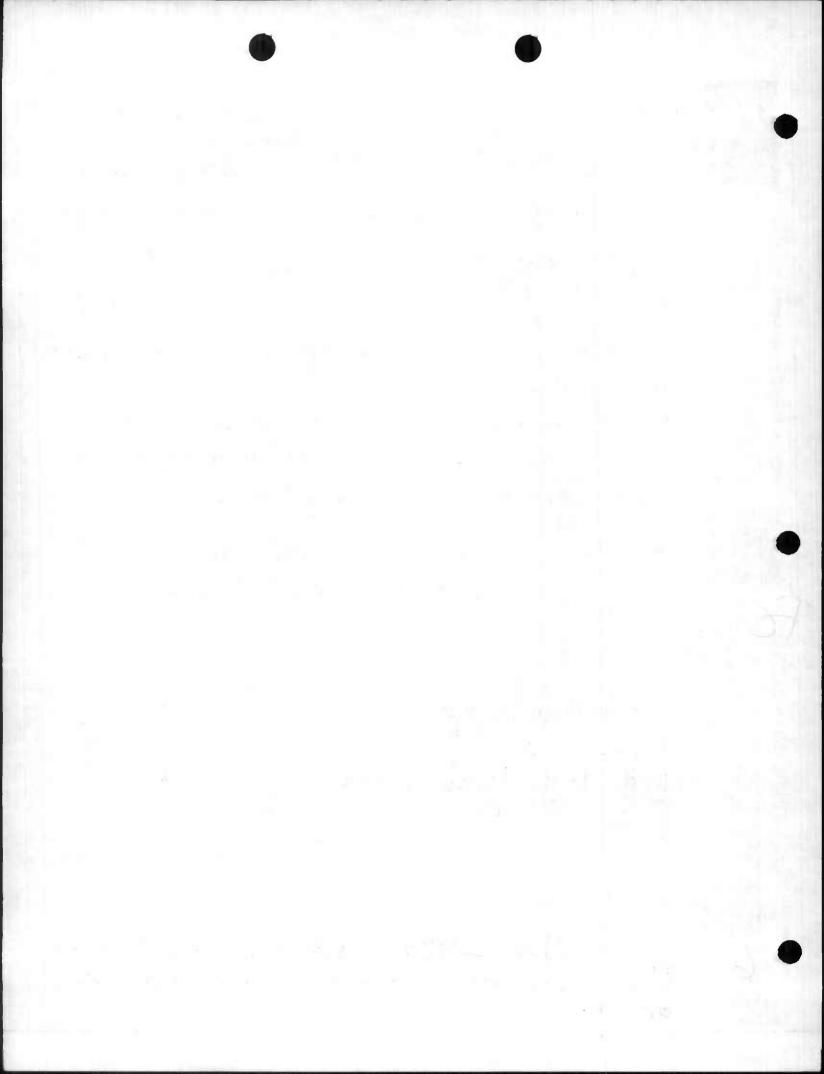


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. te of Maryland / Department of Health ar ental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month **Physician** WILSON ionstance 7:45 mg /Medical 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Bon BALTIMORE HOSPITAL Secoun A If Under 1 Year 7. Age (In yrs. lest birthday) if Under 24 Hrs. 8. Date of Birth (Month, Dey, /2-/-9. Birthplace (Stete or Foreign Country)
MAY LONG 5. Social Security Number **Funeral** 1□M 20F Months Days 217-24-1644 Yrs. Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at NIA Bactimore 1 Yes 2 No Md Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 2410 Edmondson 21223 45A Items 23a Ave. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American indian, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status traumatic event, the Medical Examiner. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 PNo Specify: "natural", or þ Specify: BLACK 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mantal Hygiana. Important: If from 27 is marked other than any injury or other fraumatic avant. College (1-4or 5+) Elementery/Secondery (0-12) Adminstration 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) CORA Powe/ WAVERLY NEW MAN 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Michelle Lawson-Daughter 20e. Method of Disposition / 20b. Pla BALTIMUTE Md 410 N. Eytow St. 20b. Placa of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 3/7/98 KING MEMORIAL BALtimore, Md 21244 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adway Baltimere, md 21213 Milles Miller P.C. Fynerst Home + Service 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in deeth) **Examiner** Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Lest Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 80 attending for use es 950 P.O. ht/flutting to deeth but not resulting in the underlying cause given in Pert !. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown ate has been signed pege 2 should be de Records, Be Completed by 24b. Were eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1□ Yes 2NNo certificate 1 Tyes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, I 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2NNo 2 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28c. injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurei Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, death occurred at the time, date and piece, end due to the cause(s) end manner stated. 29a. Certifier Medical 29b. Signature and little of certified 29c. License number 29d. Date signed (Month, Dey, Year) s of person who completed cause of death (Hem 23e) (Type, Print)

A. BEURAN (1940 W. BALT 30. Name and addre BELTRAM ST 31. Date filed (Month, Dey, Yeer) State Registrar



TO BE COMI	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If them 28 is marked, or teem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
he funeral director, page 5 should be detached.	TO THE PUREFUL DIPECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the less with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
r death. Page 6 may be retained by the hosp	TO THE COST NATIONAL PRESIDENT PRESIDENT. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host

	1 - FOR STATE STATE REGISTRAR	E OF MARYLAND		MENT OF H		MENTAL HYGIEN	E	6 (07312
	1. DECEDENT'S NAME (First, Middle, Last) ANEILJA	E. WA	LLA		DEATH	2. DATE OF DEATH MONTH DA	0319	YEAR 198	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX 1 _ M		YRS.	F UNDER 1 YEAR DAYS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Vear) 3 / 15 / 19	23	Country	PLACE (State or Foreign
TOR	99. FACILITY NAME (II not institution, give street end not institution.) Millennium Health RESIDENCE OF DECEDENT				R LOCATION OF DE Burnie	EATH		NTY OF DE	rundel
DIRECTOR	MD Anne Art	undel		own or Locat Sadena					10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL	304 Winston Rd.				21122		Uni		State _S
ВУ	1 Never Merried 2 Merried FOR	DECEDENT EVER IN U.S. A CES? 1 1 YES 2 1 ES, GIVE WAR OR DATES	RMED NO	If yes, sp		NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	or No-	14. RACE Black, Specify	- American Indian, White, atc. White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed Elementary/Secondary (0-12) College)	Give kind of work b. Do NOT use n	ual occupation done during money detary	N st of working	16b. KIND OF BUS			
BE COM	17. FATHER'S NAME (First, Middle, Lest) Felix Rutkus				18. MOTHER'S NA unkn	ME (First, Middle, Malden			
10	19•. INFORMANT'S NAME (Type/Print) Valerie McGee	1				Poute Number, City or Town			90
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetlon 3 Removal from 4 Donetlon 8 Other (Specify) Enton 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	State cemetery c	rematory or other	ark Co	matary	Ambros	1+4 m	or Tow	MD
	· Oland Ind	Noll		1328	Sulphu	r Spring	Rd.	Ark	outus, MD
	23. PART I. Enter the diseases, or complice shock, or heart fellure. List only IMMEDIATE CAUSE (Final disease or condition resulting in death)	one ceuse on each iff one ceuse on each iff one babbe Due to (or as a consider of the property) Due to (or as a consider of the property)	10.	e					Approximate interval Between Onset and Death
CERTIFICATION	Cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONSI		th'c	Coror	-ary art	eryo	lotes	o years
ERT	that initiated events resulting in death) LAST								
PHYSICIAN: MEDICAL	PART II. Other significent conditions contrib A Liminal DID TOBACCO USE CONTRIBUTE	aontic	-Che		onhage	PERFOR 1 YES 2	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPI	26. PLA	CE OF OEATH (Check only one)		6 Other (Specify)			
ву РНУ		. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJI	JRY AT	28d. DESCRIBE HOW II	NJURY OCC	CURED	
	3 Suicide 8 Could not be 4 Homicide determined	. PLACE OF INJURY — At h building, etc. (Specify)	ome, ferm, atre	et, fectory, office		281. LOCATION (Street e City or Town, State)	nd Number	or Rural Ro	ute Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the medical examiner: On the								end manner ee stated.
BE	290 SIGNATURE AND TITLE OF CERTIFIER	les 1	m		29c. LICENSE NUM		29d. DATI	E SIGNED (Month, Day, Year) H 03 1998
임	30 NAME AND ADDRESS OF DEBEON WAS COMPLE	TED CAUSE OF DEATH AT			174	6/	- //	AJOIC	11 00 1998

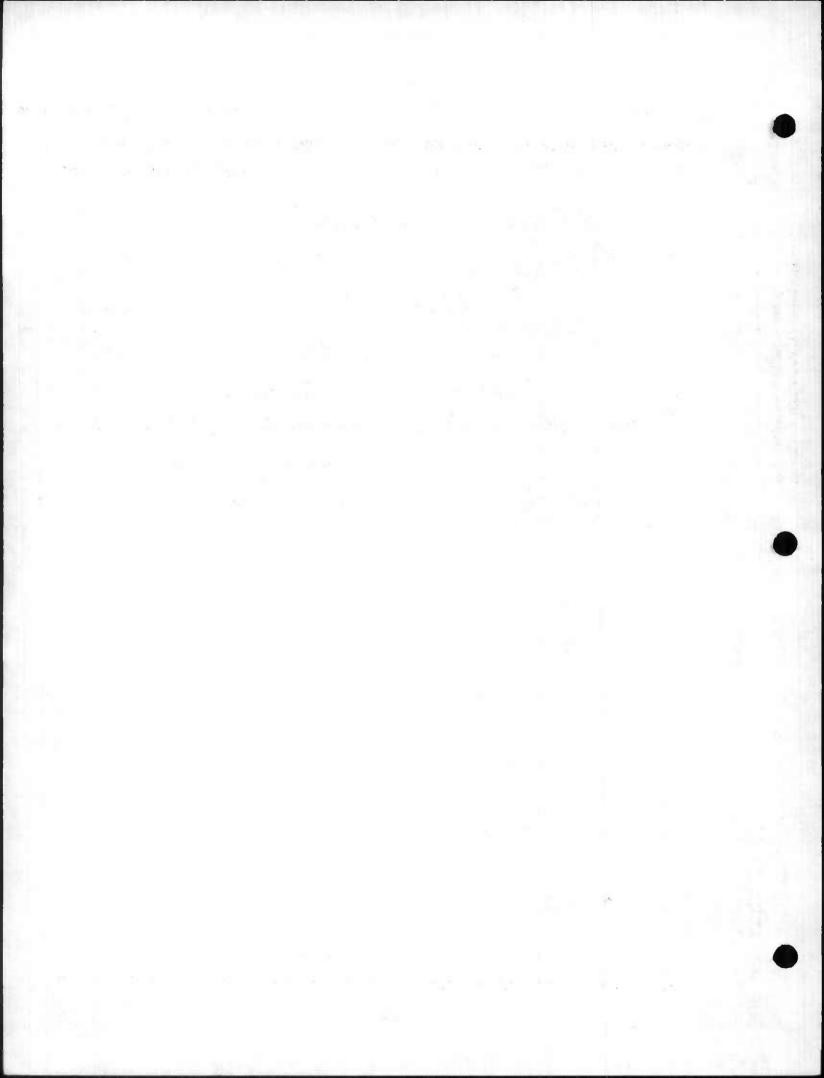
igation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end PLETED CAUSE OF DEATH (ITEM 27) (Ty

31. DATE FILED (MONTH)
MAR Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1. Decedent's Nama (First, Middla, Last) 2. Date of Death	3. Tima of Death
- 8	Physici		Er Nest Lewis Williams March 4	Year
	/Medic		4e. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County	
	Examir	ier		TIMORE
-	Funeral			
	Funeral Director		5. Social Sacurity Number 216-34-0210 6. Sex 7. Age (In yrs. last birthday) 18 M 2 F 58 Yrs. 7. Age (In yrs. last birthday) 18 M 2 F 58 Yrs. 7. Age (In yrs. last birthday) 18 M 2 F 58 Yrs. Months Deys Hours Min. Min. Mar. 22, 1939	9. Birthplece (State or Foreign Country) Balt., MD.
	tand tand		10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Mary	ō	MD BATIMORE Wordlawa	1 □ Yas 28 No
•	r 28s	Director	10e. Street end Number 10f. Zip Code 10g. Citizen of N	What Country?
	death with the Maryland ms 23s or 28s-f show From the notified at		6537 Woodgreen Circle 21207 45	A
	deat	Funeral	11. Marital Status 12. Wes Decedant Evar in U,S. 13. Wes Decedant of Hispanic Origin? (Specify Yes or No- 14. Rac	e - American Indian,
20	d within 72 hours after death with the Maryler Jene. r than "natural", or items 23e or 28e-f show the Madical Examinal must be notified at	by Fu	1 Nevar Merried 2 Married 1 Nevar Merried 2 Married 1 Nevar Merried 2 Nevar Merried 2 Nevar Merried 2 Nevar Merried 2 Nevar Merried 2 Nevar Merried 1 Nevar Merried 2 Nevar Me	ck, Whita, etc.
5-0020	within 72 hours ene. than "natural", he Medical Exa			Usinass/industry
	nin 72	Completed	(Specify only highast grade completed) (Give kind of work dona during most of working	Government
12121	filed with Hyglene ther that	ШО	Elementery/Secondary (0-12) Collega (1-4or 5+) Soldiel U.S. W	Military
	should be filed and Mental Hygi marked other matic evant, t	Be C	17. Fsther's Nama (First, Middle, Last) 18. Mothar'a Nama (First, Middle, Meiden Surman	na)
a	Mental Mental arked o	ToB	Henry E. Johnson Wipla William	6
Maryland	2 should and Mer la marke aumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town,	
	Haalth em 27 lead		Pauline Williams-wite 6537 Woodgreen Circle, Woodlaw	N.M.D. 21207
altimore,	of Ha			City or Town, State
altimo	Pages nent of I ant: If its ury or o		4 Donation 5 Other (Specify) Garrison Forest Het. Cem 13-9-98 Owings	mdk, mD
alt	permit. Pages 1 and 2 should be filed Department of Haalth and Mental Hy, Important: if item 27 Is marked othe any injury or other traumatic event, once.		21. Signeture of Funaral Service Licensea 22. Nama and Addrass of Facility Albust P. wyl	ie 7/HPA
m	20 = 20		630 N Gilan Short Bolling	-40 71717
			23a. Part 1. Entar tha diseesa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
	Physician	8 4	and the state of t	Onset and Death
4	/Medical Examiner	Ľ,	Immediata Cause (Finel disaasa or condition NON SMALL CELL LUNG CANCER	MONTHS
		_	rasulting In deeth) Due to (or as a consaquance of):	
	sit ed	line	b .	
	ficate be executed g physician and as the burlat-transit	Examiner	Sequentially list conditions, if env. leading to immediate	
09	be e iiclan buris		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as a consequence of):	
68760,	ficata p phys is the	edicai	rasulting in death) Last Due to (or as s consequence of):	
	eath certifi attanding for use as		d	
Box	atta d for	Physician/M	Dad II Other standings and disease could be a could be	
0	the c	hys		ntribute to the cause of death? 3 Probably 4 Unknown
G.	The law requires that the death cert lite hes been signed by the attanding page 2 should be deteched for usa	by P	HIV 110 Yee 2 No	3 Probably 4 Dinknown
Ď	quira en sig	B	24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to
သို့	s be	Completed	perometr	completion of ceuse of death?
ď	Tha law ata hes page 2:	Eo	1 → Yes 2 → No	1□Yas ŽiNo
		BeC	25. Was casa rafarred to medical 26. Place of Death (Check only one)	
ta	T 7.0	To	axaminar? 1 Yas 2 No	er (Specify)
f Vital Records, P.O.	8 00		27. Menner of Death 28e. Deta of figury 28b. Time of 28c. Injury at 28d. Describe how injury occur	
n of Vital	the sta	n:		
Sion of Vital	the sta	ation: T	2 Accident Invastigation M 1 Yas 2 No	
n of	the sta	tification: T	2 Accident Invastigation 3 Suicida 6 Could not be determined determined determined.	per or Rural Route Number,
n of	the sta	Certification:	2 Accident Invastigation 3 Suicida 6 Could not be 28s Place of Injury - At home farm street factory office 28f Location (Street and Number)	per or Rural Route Number,
n of	the sta	Certification:	2 Accident 3 Suicida 4 Homlolda 29a. Certifiar (Check only) 29 Medical Examiner: On the basis of examination and/or invastigation invastigation 1 Vas 2 No 28f. Location (Streat and Numbration) 28f. Location (anner as stated.
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n of	Hoteptar or mandaling Physical Calendar Physical Calendar Aler this areay litted in by the Kineral distriction of the Calendar Calendar III areas to the Calendar III areas to	Certification:	2 Accident 3 Suicida 4 Homloida 28a. Piece of Injury - At homa, farm, streat, factory, office 28b. Certifiar (Check only one) 28c. Certifying Physician: To tha best of my knowledge, daath occurred at the time, data and place, and due to tha causa(s) and me one of an importance of a samination and/or invastigation, in my opinion, deeth occurred at tha tima, date and place, and mennar atated.	anner as stated.
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Items:1, 29d per M.D G-757 3/9/98 reGertificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey MALLE tella 17,1998 11 February MARIE ZELLER pm 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death JOHNS HOPKINS BAYVIEW HOSPITAL BALTIMORE 8. Dete of Birth (Month, Dey, Year) Jan. 9,1912 MARYLAND If Under 1 Year 9. Birthplece (State or Foreign If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) Deys Months 1□ M 2/5/5 215-09-5785 86 Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location XXYes 2 No N/A BALTIMORE 10e. Street end Number 10f. Zlp Code 10g, Citizen of What Country? 924 S. HIGHLAND AVENUE 21224 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2X No Specify: WHITE Specify: 3 ₩Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) JOHN SISOLAK KATHERINE 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) GERARD ZELLER/SON 989 WAYSON WAY, DAVIDSONVILLE, MD. 21035 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) SACRED HEART OF JESUS 2/20 BALTIMORE, MD. 22. Name end Address of Fecility CHARLES S. ZEILER & SON INC. F.H. 21. Signeture of Funeral Service Licenses 6224 EASTERN AVENUE/21224 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest shock, or heert feilure. List only one cause on each line. Approximete intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) AitEriocalorti CARDIOVASular Dison Due to (or es e consequence of): Due to (or es e consequence of):

Physician /Medical Examiner

physician

the signed by

need hes

this certificate

sepital or Attending Physician: Thours efter death.

Insert Director: After this certificate filled in by the funeral director, pa

Hospital 24 hours e

To the F within 24 To the F complete

Mel

page 2 should Completed

by 8

Be

Certification: To

Medical

The law requires that the death certificete be executed

Box 68760

P.O.

Division of Vital Records.

Physician

/Medical

Examiner

10a. Stete

MD.

Funeral

Director

28a-f show

Director

Funeral

by

Completed

7 is marked other than "natural", or items 23a or 28a-f shov traumatic avent, the Medical Examener must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or iten any injury or other traumatic avent, the Medical Exercises once.

Maryland 21215-0020

altimore,

with the Meryland

death

Examiner bunel-tran Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Physician/Medicai the

Due to (or es e consequence of):

Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown

24e. Wes en eutopsy

24b. Were eutopsy findings available prior to completion of cause of death?

26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25.		r <i>e</i> rrea	to medical
	examiner?		
	1 ☐ Yes	2 NO No	
	. 🗀 . 00	-400	

27. Menner of Death Neturel

2 Accident

3 Suicide

4 | Homicide

5 Pending investigation 6 Could not be determined

Emestin

Hospitel: 1 ☐ Inpatient 28e. Dete of Injury (Month, Dev Yeer)

2 ER/Outpetient 3□ DOA 28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certitier (Check only one)

🔁 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end manner es stated. 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier

29c. License number 24276 29d. Dete signed (Month, Dey, Year) 2/18/98

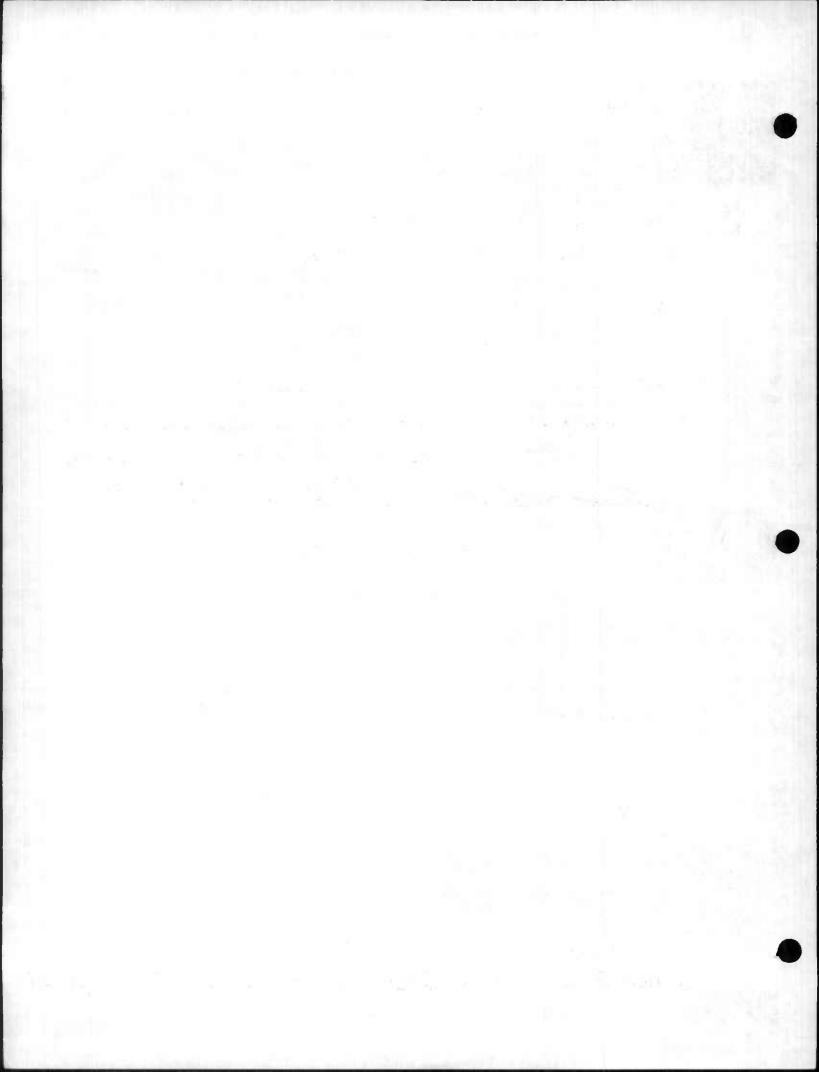
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scalia m.D.

HUDSON STREET BALTO, 21234 2801

31. Date filed (Month, Dey, Year) State FEB 2 5 1998 Registrar

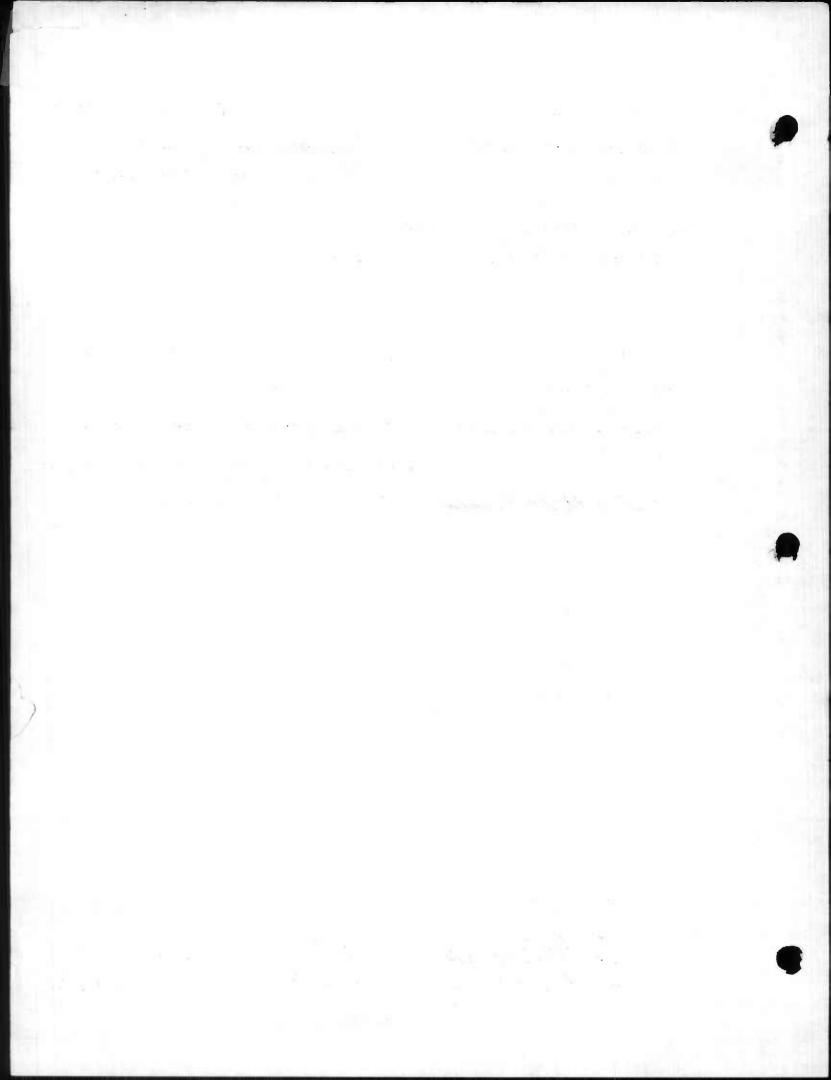
32. Registrer's Signature Sulia Davidson-Randall

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

						Cen	tificate of	Death	Reg	. No. 9 8	07315
	Physici	an	1. Decedant's Name (First, Middla, Last)						2. Data of Daeth Month	Day	3. Tima of Death
	/Medic		Vera Marie Adams						Feb	17	1998 18 49
	Examir	er	4e. Facility Nema (If not Institution, giva					4b. City, Town, or	Location of Deeth	4c. County of	
4			Washington County 5. Sociel Security Number 6. Sec		1 1 ne (In yrs. las	a foliath air cal	If Under 1 Year	Hagerst		Washi	9
L	Funeral Director			M 2DXF	73	Yrs.	Months Days			^(ear) 1924	9. Birthplace (State or Foreign Country) Maryland
	ylend		10a. Stata 10b. County		10c. City, 1	Fown or Loc	ation				10d. Inside City Limits
	or 28s-f shorter	Director	Maryland Washing	ton	Во	oonsbo	ro				1 □ Yas 2 1 No
	it to 20 20 20 20 20 20 20 20 20 20 20 20 20	Dire	10e. Street and Number				10f. Zip Coda		100	. Citizan of W	het Country?
	23a		20767 Beaver Cre				2171			U.S.A.	
Baltimore, Maryland 21215-0020	2 should be filed within 72 hours effer death with the Menyland sand Mental hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Example, must be notified at	by Funeral	11. Merital Status 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant Armed Forces? 1 ☐ Yas 2XII If Yes, Give Yaar or Datas:			/as Decedant of I Yas, specify Cub ☐ Yes 2 XNo	Hispanic Orlgin? (Sean, Maxican, Puerl Specify:	pecify Yes or No- to Rican, atc.)		a-Amarican Indian, k, Whita, atc. White
5-0	72 ho	eted	15. Decedant's Educ (Specify only highast grade	cation complated)	1	16a. Deceda	ant's Usuai Occup	pation during most of wo	rkina 16	b. Kind of Bus	sinass/Industry
121	d within giene. The Me	Completed	Elementery/Secondary (0-12)	Collega (1-4or :	5+)			od)		Floots	da Company
2	Hygie Hygie rr, th	ပ္ပ	0-12 17. Fether's Neme (First, Middla, Last)	0		C)	Lerk	18 Mother's Ner	ma (First, Middla, Ma		ric Company
an	d be filed ental Hyg ced other c event,	o Be	Walter R. Hutson					Mae	1101) 111100101 1110	routi ourrattio	,
ary	d 2 should th and Mer 7 is marke traumatic	To	19a. Informant's Name/Ralationship (Ty	pe, Print)		19b. Meiling	Addrass (Straa	t and Number or Ri	urel Routa Number, (City or Town, S	Stata, Zip Code)
Σ	and 2 27 is 27 is		Charles A. Adams	- Husba	and	20767	Beaver	Creek Ro	oad Boor	sboro,	Md. 21713
Jre,	iges 1 and 2 nt of Heelth if Nem 27 is or other tra		20e. Mathod of Disposition		20b. Pled	e of Dispos	ition (Nama of atory or other pla	ice)	Deta 20	c. Location - 0	City or Town, Stete
Ē	Pages nent of h int: If its iry or or		1 XBurial 2 ☐ Crametion 3 ☐ R 4 ☐ Donetion 5 ☐ Othar (Specify)	amoval from Stata			en Cemet		2-20-98 H	lagerst	own, Maryland
a	pemit. Pag Depertment Important: I any injury o		21. Signature of Funerei Sarvice License	18 -	-		Nama end Addre		innich Fur		
00	80 2 8 9		2 Cath	nones	ul	41	l5 E. Wi	lson Blv	d. Hagers	stown,	Maryland
			23a. Pall 1. Enter the disease, or compile shock, or heart failure. List only or	cations that causer a causa on each ii	the death.	Do not ante	r the moda of dyl	ng, such es cardie	c or raspiratory arres	t,	Approximete totarval Between
N	Physician										Onset end Death
1	/Medical Examiner		Immedieta Ceusa (Final disaasa or condition rasulting in daath)	M	700	Avd	141 12	foret	0 1		minutes
		<u>-</u>			Due to (or e			}			
	uted Insit	Examiner	C 1	. ————	D		1-0				
ó	icete be executed physician end s the buriel-transit	Еха	Sequantially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disaasa or Injury		Dua to (or as	s a consequ	lance or):				
68760,	ysicie	edicai	Cause (Disaasa or injury that Initiated avents rasulting in deeth) Last		Due to (or es	s e consequ	ance of):				
4.4	ng ph	5									1
Box	eath ce ettendii for use	lan/	d								
	the e	Physician/	Part ii. Other significant conditions con	tributing to death b	ut not rasultir	ng in tha un	darlying cause gi	ven in Part i.	23b. Did tob	acco usa con	tributa to the cause of death?
P.0	requires that the death certificate be executed seen signed by the ettending physician end hould be deteched for use as the buriel-transit		diabet	2-5					1 🗆 Yea	2 No	3 Probably 4 Unknown
ds	sign d be	d by							24a. Was an	autonsv	24b. Wara autopsy findings
00	_ L/ (r)	Completed							performe	ed?	available prior to complation of cause
Re	The lew ete hes b page 2 s	E							4 El V	₩ □111-	of death?
ta	ician: Th certificete rector, pay		25. Was casa referred to medical					26 Piego of Do	1 ☐ Yas ath (Check only ona)	20 No	1 Yas 2 No
>		To Be	eveminer?	ospitei:	ent 2DER	VOutpetient	3 DOA Ot	har	tome 5□ Residan	ce 6 ∏Otha	r (Specify)
10	g Physer this		27. Mannar of Death	28a. Data of Inju (Month, Da		Bb. Tima of Injury	28c. inju		28d. Dascribe how		
io	Attending For death. ector: After by the funer	atio	1 Anaturai 5 Panding invastigation	(INOTHI, Da	y roar,	Injury		Yas 2□No			
Division of Vital Records,	r Atte ter de frecto n by ti	Certification:	3 Suicide 6 Could not be datarminad	28a. Piace of inj	ury - At home c. (Specify)	a, farm, stre	at, factory, offica		28f. Location (Stra City or Town,	at and Numbe Stata)	er or Rurel Routs Number,
	oftai or urs efte rai Dir illed In										
	To the Hospital or Attent within 24 hours efter deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medicai Examin	ician: To the best er: On the basis of and mannar st	axamination	edga, death on and/or inve	occurred et the ti estigetion, in my o	me, date end piece opinion, deeth occu	e, and due to the ceu arred at the tima, date	se(s) and mar s and pia <i>ce</i> , a	nnar as stated. and dua to tha causa(s)
	within 2 To the comple	Mec	29b. Signature and title of gentiller	and mannar St	ateu.		29c. Lican	sa number	290	I. Data signed	(Month, Day, Year)
	⊢≯Fŏ		1/1/1/	20 D	100					Feb 1	7 98
			30. Name and address of person who co	mplated cause of d	laeth (Itam 23	3a) (Tvna P	Print)	11266 4 thorn		1	- 10
			H. N.	Helks	M.D	(· J pu) I	580 N	livThorn	Av A	11402	stour her
T	Sta Begistr	_	31. Deta filad (Mohth, Day, Year)	32. Registr	S Constur		0.2.00		16	1	



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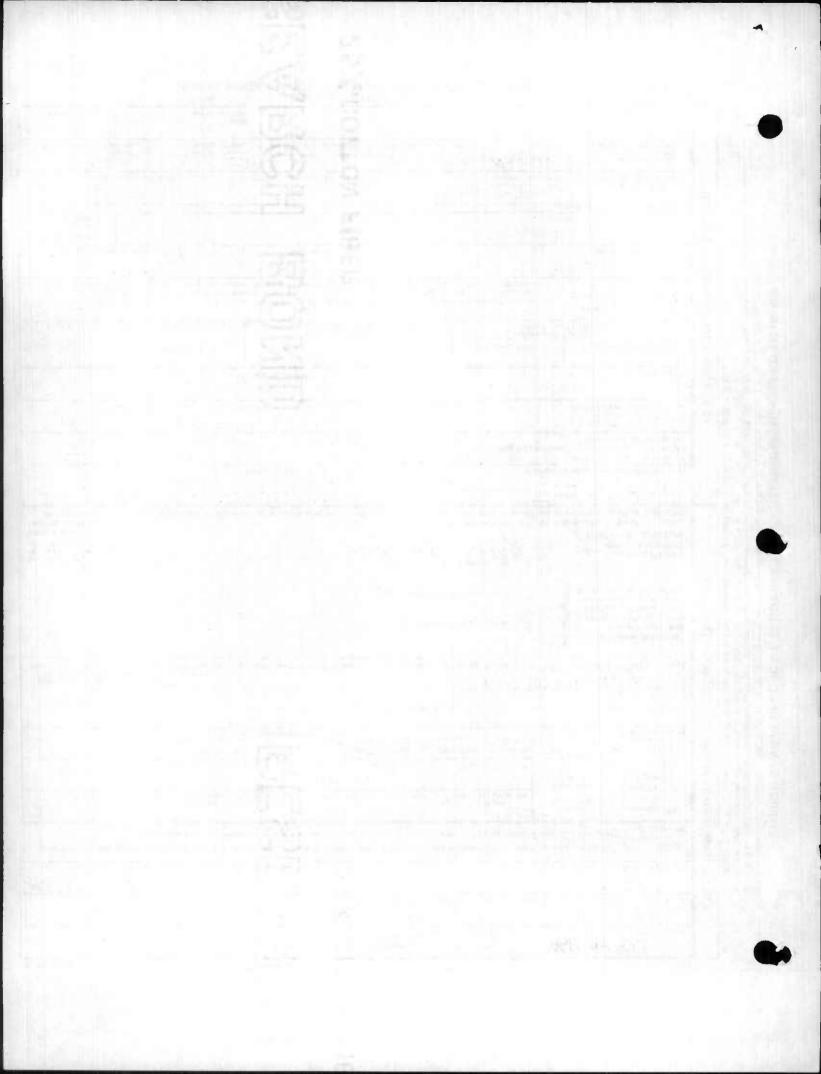
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Tours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mernal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any Inlury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR CERTIFI	MENT OF H	EALTH AND	MENTAL HYGIENI REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	Hazel	Baker			2. DATE OF DEATH	23, 1998	3. TIME OF DEATH 3 2:00PM M
	4, SOCIAL SECURITY NUMBER 206-40-8340		n yrs. last birthday) . .03 vns.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day Year) August 17, 18	9 BIDT	THPLACE (State or Foreign nitry) Nna.
OR	9a. FACILITY NAME (II not institution, give s RAVENWOOD LUTHE)	reet and number) RAN VILLAGE		HAGER	STOWN		9c. COUNTY OF WASHIN	
DIRECTOR	10a. STATE 10b. COUNTY Maryland Was	nington		gerstow		DE N		10d. INSIDE CITY LIMITS? 1 (X) YES 2 NO
FUNERAL (100. STREET AND NUMBER 1183 Luther Dr.				21740		10g. CITIZEN OF	WHAT COUNTRY?
BY	11. MARITAL STATUS 1 Nover Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, sp-		NIC ORIGIN? (Specify Yea in, Puerto Rican, etc.) y:	or No — 14, RAG	CE - American Indian, ck, White, atc.
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 12	CATION completed) College (1-4 or 8 +)	18a. DECEDENT'S I (Give kind of w life. Do NOT use Homem	ork done during mo e retired.)	ON st of working	166. KIND OF BUS		
BE CON	17. FATHER'S NAME (First, Middle, Last) Conra	nd Baker				a Nora Johr		
TO B	Paul E. Pritts					n, Pa. 1553		
	20a, METHOD OF DISPOSITION 1 M Burlal 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	oval from Stata ceme	PLACE AND DATE OF OFF OFF OFF OFF	Cemeter	ry 2/	/28/98 Ber	cation - chy or lin, Pa	
	21. SIGNATURE OF FUNERAL SERVICE LIC	Zennen Z	5~.	Zimme	erman And Carlis	d Son Funer le St. Gree	ral Home	Inc. Pa. 17225
CERTIFICATION	23. PART i. Enter the diseases, or on shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that intileted events resulting in death) LAST	a. DUE TO (OR AS A DUE TO (OR AS A	the death. Do nich line. Dulli CONSEQUENCE OF CONSEQUENCE OF	tea D:	de of dying, suc	th an cardiac or reapi	ratory arreat,	Approximate interval Between Onset and Daeth
PHYSICIAN: MEDICAL CE	PART II. Other eignifigent condition	a contributing to death bu	ut not reaulting in	n the underlying	g cause given in	Part i. 24a. WAS AN / PERFORI	MED?	ib. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpa	etlent 3 DOA	OTHER	ACE OF BEATH (Ch	6 Other (Specify)		
ВУ РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU	OF 28c. INJ	URY AT	28d. DESCRIBE HOW IN	JURY OCCURED	
0	3 Suicide 6 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY building, atc. (Speci	— At home, farm, et	treet, factory, offic		26f. LOCATION (Street a: City or Town, State)	nd Number or Rure	Route Number,
COMPLET	anal	CIAN: To the best of my knowle R: On the bests of examination						(s) and menner sa stated.
BE	296. SIGNATURE AND TITLE OF DERTIFIER	hau, mo		7.3	29c. DICENSE NUI	655	29d, DATE SIGNE	B. 23 1998
2	30. NAME AND PURESS OF PERSON WH	COMPLETED CAUSE OF DEA	TH (ITEM 27) (1)00.	Print) Hog	us for	in mi	20 317	40
	31. DATE FILEO (MONTH, Day, Year) FEB 26 1998	Juna David	77 6 4					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death Month 4c. County of Deeth 4b. City, Town, or Location of Deeth Hagerstown, Washington If Under 1 Yaar If Undar 24 Hrs. Months Davs Hours Min. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Days 15M 20 F Yrs. 79 Jan. 8, 1919 MD 10b. County 10c. City, Town or Location

1. Decedent's Neme (First, Middle, Last) **Physician** 0100 Woodrow Wilson Blover /Medical 4e. Facility Name (If not institution, give street end number) **Examiner** Washington County Hospital 5. Social Security Number Birthplace (Stete or Foreign Country) **Funeral** Director 217-12-1499 Usuel Residence of Decedent 10a State 10d. Inside City Limits 28a-f show must be notified at Washington Big Pool 1 ☐ Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21711 234 12766 Indian Springs Road U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, atc. traumatic svent, the Medical Examiner filed within 72 hours effer 1 ☐ Naver Merried 2 ☐ Married 1 Yes 2 No If Yes, Give Yeer or Dates: White ò 1 Yas 2 No Specify: þ 3 Widowed 4 Divorced 'natural', Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic successions." Elementery/Secondery (0-12) College (1-4or 5+) Food & Dairy Manager Supermarket Unknown Unknown Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumame) Be John Henry Bloyer Nannie M. Repp 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 12766 Indian Springs Rd. Big Pool, MD 21711 Hazel R. Bloyer 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Namoval from State Big Pool, MD 4 ☐ Donetion 5 ☐ Other (Specify) Parkhead Cem. Feb. 14, 1997 21. Signature of Funeral Sen 22. Name and Address of Fecility Thompson Funeral Home, Inc. 23a. Part 1. Envir tha disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, MD 21722 approximate shock, wheel failure. List only one cause on each line. Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in death) ardiac hour Examiner ar lew requires that the death certificate be executed Sequantially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 HASCVI Physician/Medical Dua to (or es e consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown -farlure þ 24b. Were autopsy findings available prior to complation of causa of deeth? Completed 24e. Wes en eutopsy periormed? 0. 1 Tes this certificate 2 No 1 ☐ Yas 2 ☐ No Attanding Physician: filled in by the funeral director, Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpetient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 ER/Outpetient 3 DOA 27. Menner of Deeth Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Netural death. 1 Yes 2 No 2 Accident **Director:** 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital To the Hospital within 24 hours a To the Funeral Completely filled Medical Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signature end title of certifier 29c. License number 29d. Data algned (Month, Dey, Year) 30. Neme and eddress of perso h (Item 23e) (Type, Print)

Trainia Ave. Hazerstown, rd. 21740

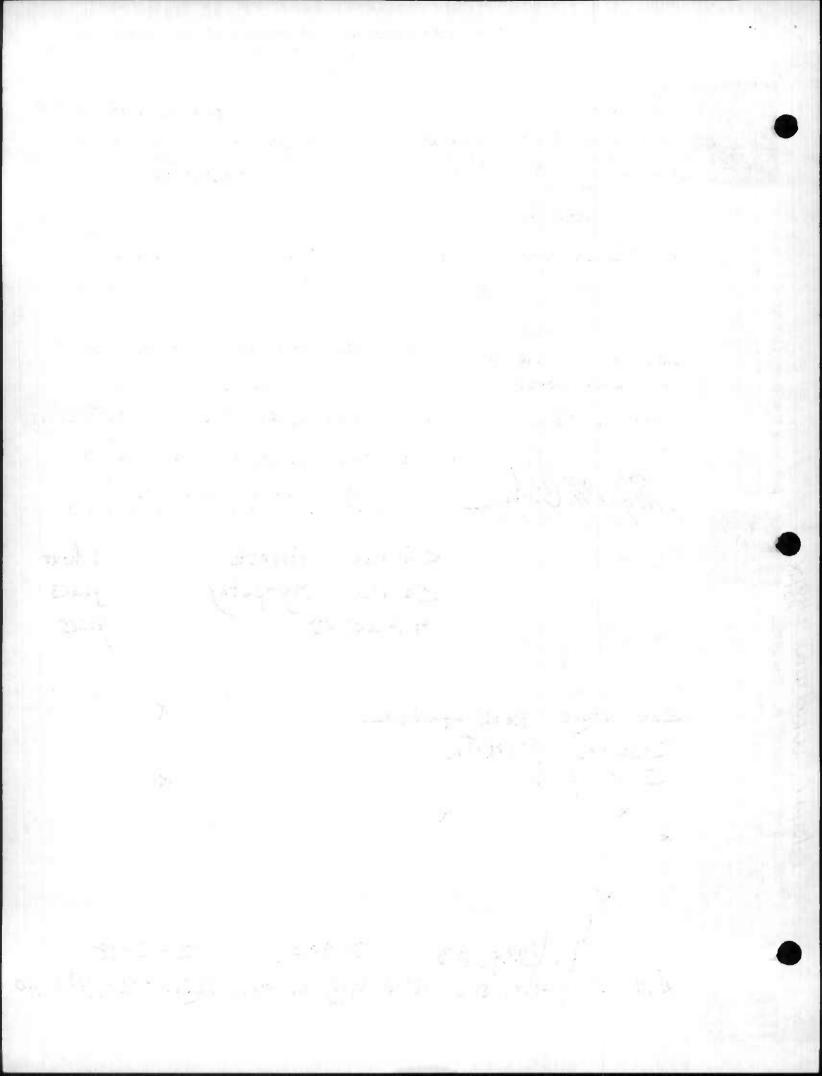
State Registrar

31. Dete filed (Month, Dey, Year)

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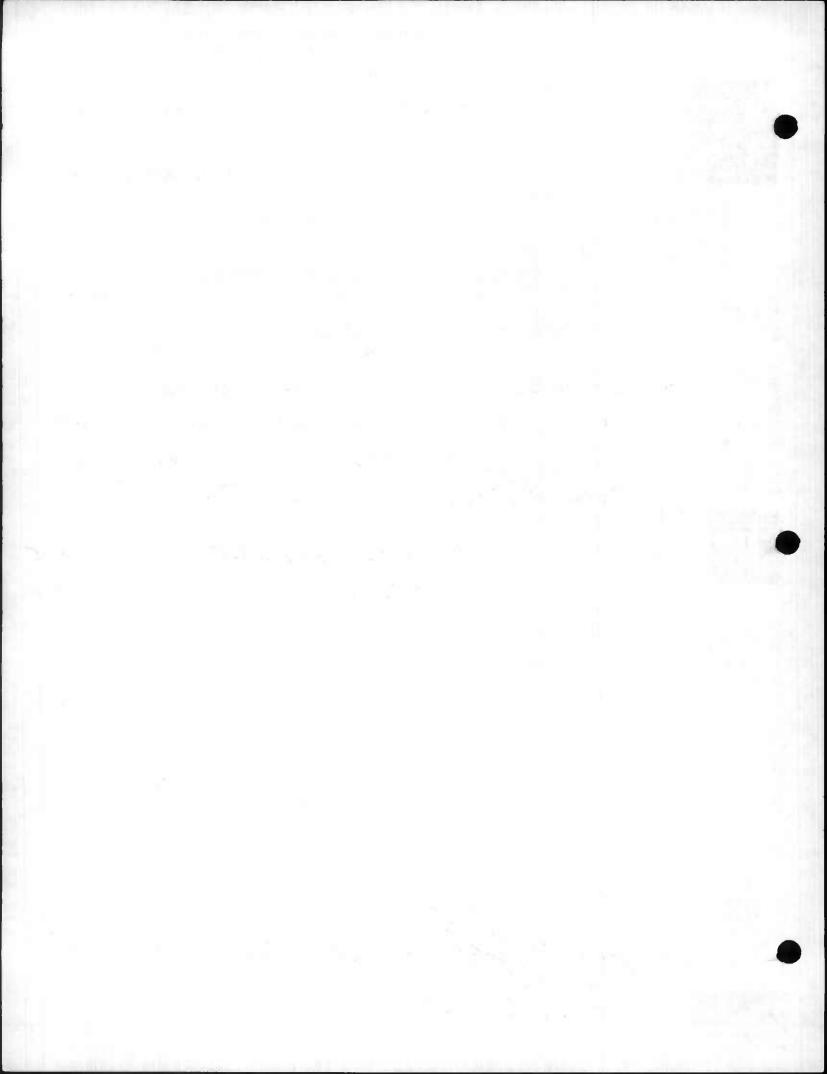
State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month CHARLES FRANKLIN BAUBLITZ FEB 20, 1998 2:00 AM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD HOUSE TANEYTOWN CARROLL If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1₽M 2□F Yrs 218-09-7770 92 Director JAN 31,1906 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Haalth and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or items 23s or 28s-f show odical Examiner must be notified at 1 Yes 2 No Director MARYLAND CARROLL TANEYTOWN 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4949 MIDDLEBURG ROAD 21787 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: þ Specify WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) FARMING BOYCE FARM h 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumama) Be GEORGE HOWARD BAUBLITZ 2 DORA ELIZABETH STROH 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) or other tra LAURA WINTERSTEIN, NIECE 850 LEISTERS CHURCH RD, WESTMINSTER, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) SALEM UM CEMETERY 2/23 HAMPSTEAD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074 une 23a. Part1. Enter the disease, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final FAILUNE diseasa or condition resulting in death) Examiner Examiner physician and the bunal-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) use as Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? signed by 1 Yes 2 No 3 Probably Munknown 20 page 2 should b 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? complation of cause of deeth? certificate has 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) axaminer? Other: Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fil 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Feb. 20, 1998 40 30. Name and address of person who compound cause of death (Item 23e) (Type, Print) John Lehigh MD, 104 N. Main St, Union Bridge, MD 21791

Registrar's Signature

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year) FEB 2 3 1998



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death

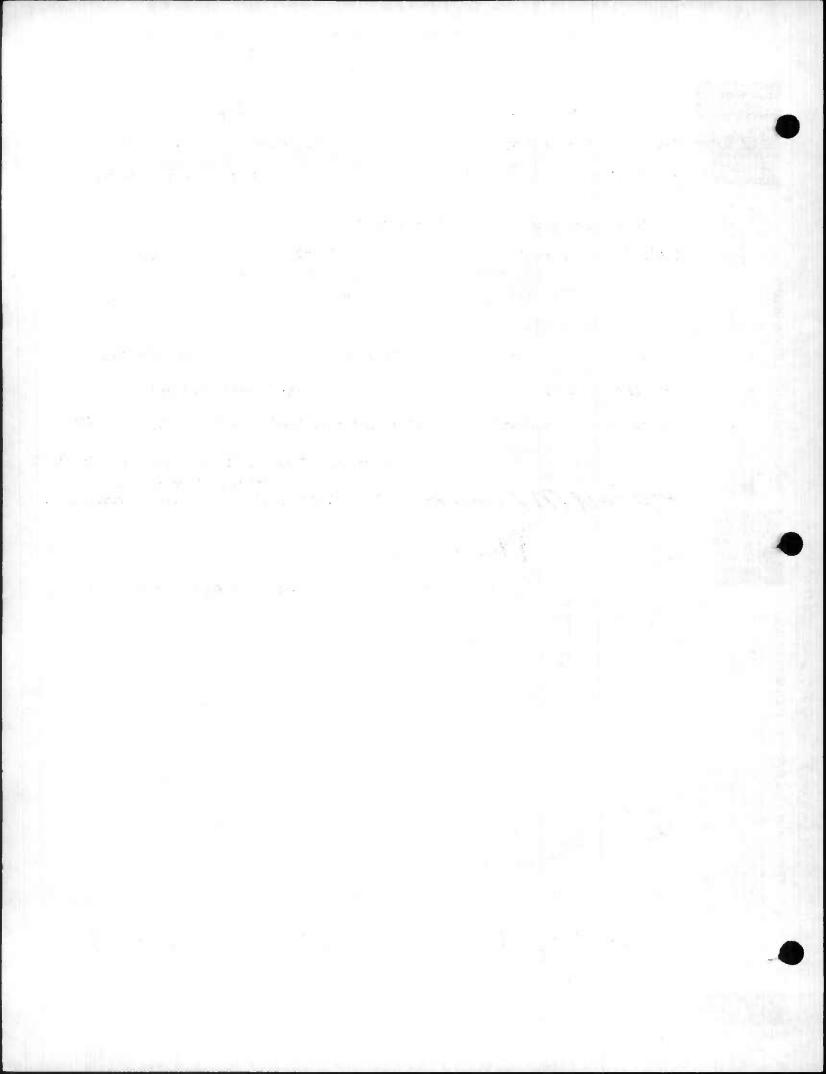
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/Medi		Marlene Elizabe						tel.	17.19	98	16:55
Examir	er	4a. Facility Nama (If not institution, g					4b. City, Town, o	r Location of Death			
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Funeral Director		5. Social Sacurity Number 6. 212-38-7765 Usual Rasidanca of Decedent	Sax 1□ M 2∏ F	7. Age (fin yrs.	Yrs.	Months Day			y, Yaar) 1940	9. Birthplaca Country) Maryla	(State or Foraign nd
No.		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. ir	nside City Limits
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of in by t	Certification:	3 Sulcide 6 Could not 4 Homicida	28a. Placa o	f Injury - At ho g, etc. <i>(Specif</i>)		aat, factory, offic	> 0	28f. Location (S City or Tov		ber or Rural Rou	te Number,
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State Registrar 31. Data filed (Month, Day, Year)

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Commer Marlene Elicobeth



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Deeth **Physician** FBBRUARY Amanda Louise CLAPPER /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** Hagerstown Washington Washington County Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 24 1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2XF Days Yrs. Pennsylvania 171-28-9578 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 X Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 U.S.A. 1102 Moller Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No It Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 - 12Teacher Public Schools 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abram F. Myers Verna Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita C. Heck - Daughter 1513 Kensington Drive Hagerstown, Md. 21742 20b. Placa of Disposition (Name of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 2-20-98 Bellwood, Pennsylvania Logan Valley Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Sepoce Licensee A Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervai Between Immediete Ceuse (Final disease or condition resulting in deeth) a. PN HUMON A

Due to (or as a consequenca ot): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NOUNO COCCAL Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown MBULTUS HYPER TON STON 24b. Were autopsy tindings eveilable prior to Completed 24a. Was an autopsy performed? GIRNEMA completion of cause of death? 1 Yes 2 No 25. Was case reterred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2No Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Naturei 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29e. Certifier Medical 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1986 MEADOW VIOW DR ARELESTONN

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State Registrar

Funeral

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To the Hospital or Attanding Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

P.O. Box 68760.

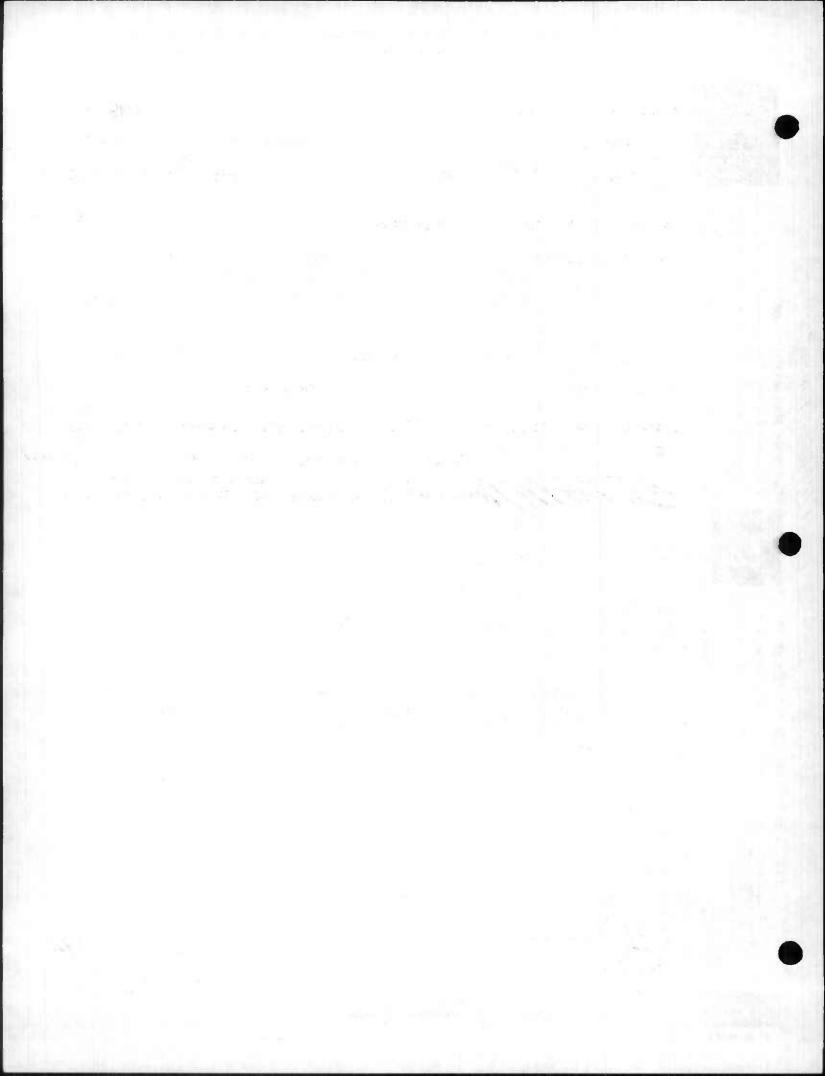
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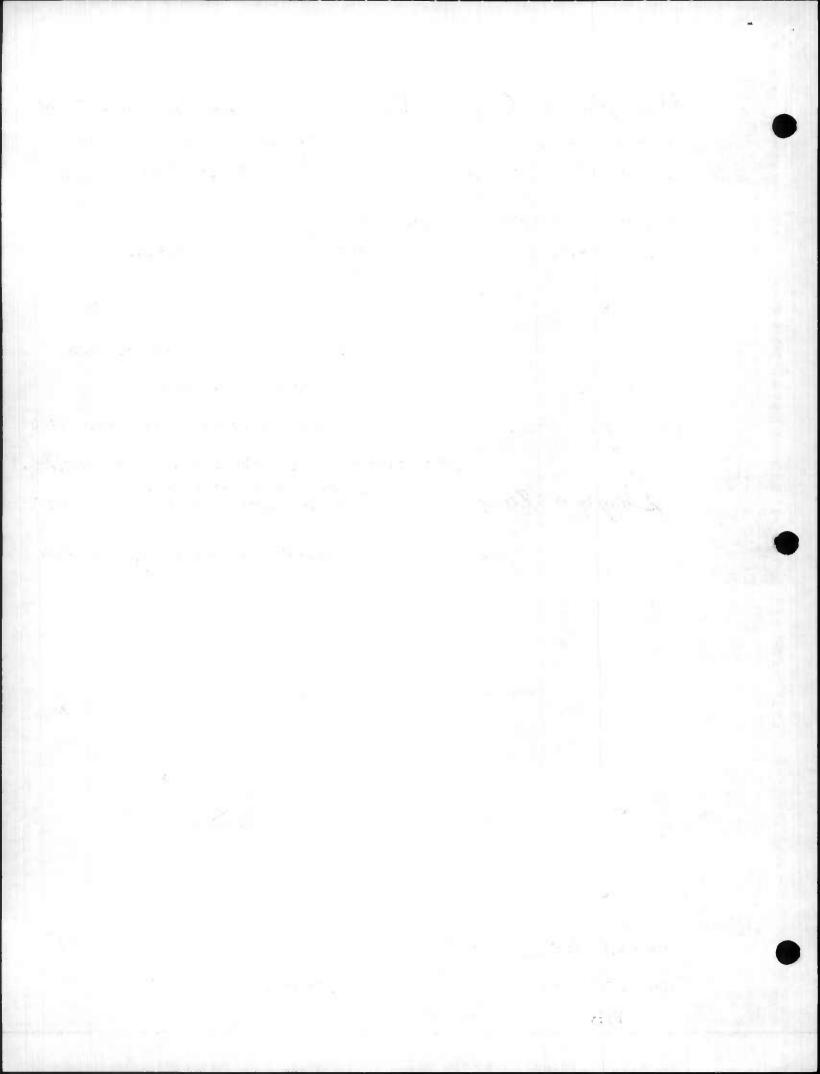
State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Data of Daath Month 3. Time of Death Capezuto Marie Alice

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Registrar

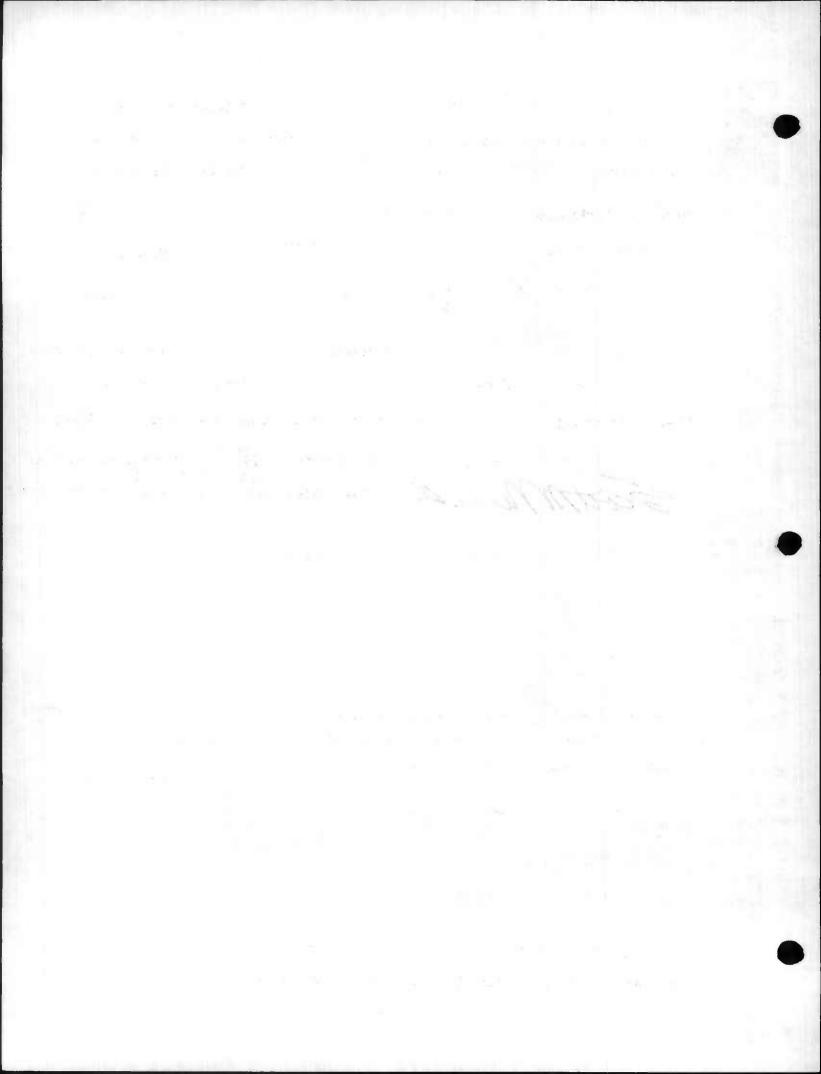
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/Medical



State of Maryland / Department of Health and Mental Hygiene 8 0 7 3 2

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey 19 98 4c. County of Deeth Cunningham 0420A Kathryn Feb 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Washington County Hospital Hagerstown Washington If Under 1 Yeer | If Under 24 Hrs. | Months | Deys | Hours | Min. | 7. Age (In yrs. last birthday). 72 Yrs. 5. Sociel Security Number Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Yeer) Deys 1□M 2√ F 174-20-8987 Pennsylvania Dec 21,1925 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Washington Clear Spring 1 Yes ZENo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 13144 Golizen Lane 21722 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Central Service Hospital Center 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John M. Straley Rhoda Angle 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Jerry L. Cunningham, Son 339 Antietam Drive, Hagerstown, Maryland 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from State Feb. 16 Cedar Hill Cemetery Greencastle, PA 4 Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lib Bouglas A. Fiery Funeral Home 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 Ins thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ause on each line. Onset end Deeth Oct 1997 Abdominal carcinomatosis Immediete Cause (Finel disease or condition resulting In deeth) Due to (or es e consequence of) 1996 Carcinoma of the colon Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting In deeth) Lest Due to (or es e consequence of): Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas X No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Was en eutopsy performed? 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one)

Physician /Medicai Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Items 23a

6

"natural",

permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If I few 27 is marked other then any Injury or other traumetr.

Maryland

Baltimore,

filed within 72 hours after death

Director

Funeral

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Completed

Be

traumatic event, the Medical Examiner must be notified at

yd bergis page 2 should After this certificate death. Director: in by To the Hospital within 24 hours a To the Funeral C

Division of Vital Records, P.O. Box 68760

mas Kathryn (unnungham

Examiner Physician/Medical þ Completed Be 2 Certification: 29e. Certifier

25. Was case referred to medical 1 ☐ Yes 2√ No 27. Menner of Deeth

1 Naturel 2 Accident

3 Suicide

4 Homicide

5 Pending Investigation 6 Could not be determined

28a. Dete of Injury (Month, Dey Year) none

28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier

G. Jagan, M. D.

29c. License number D05821

29d. Date signed (Month, Dev. Year) Feb 13, 1998

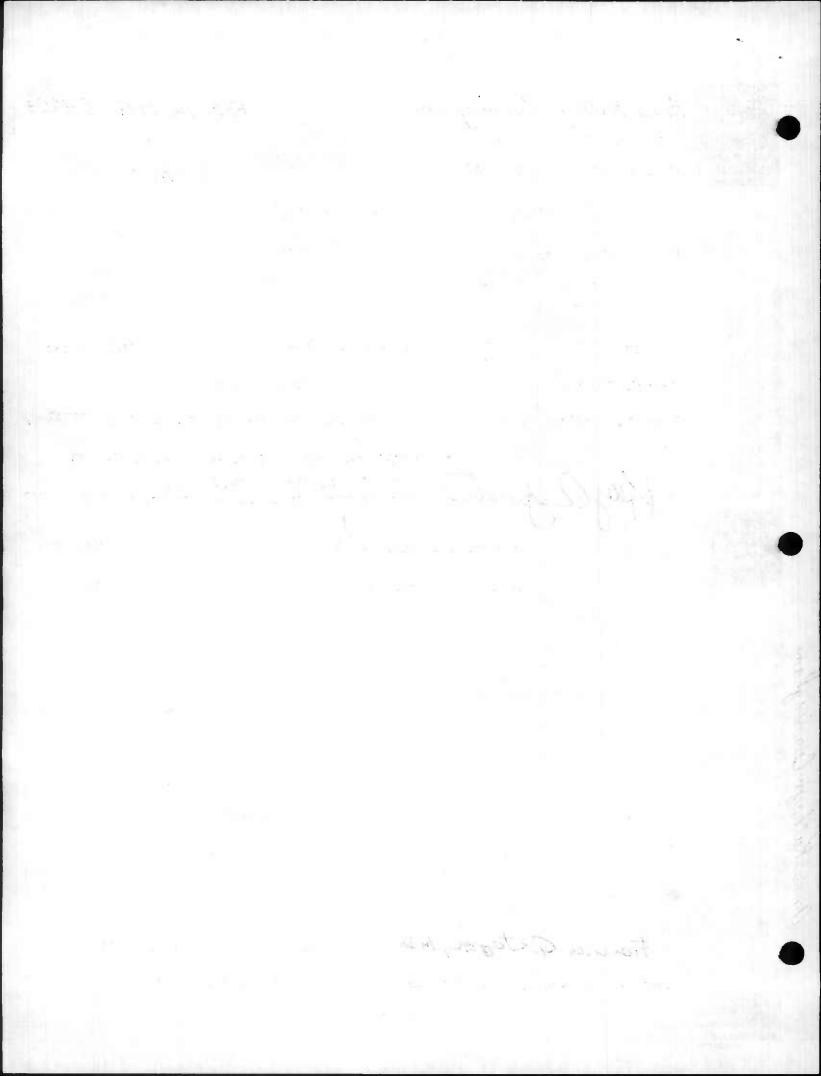
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Francisco G. Japzon, M.D. 346 Mill Street, Hagerstown, MD. 21740

State Registrar

Medical

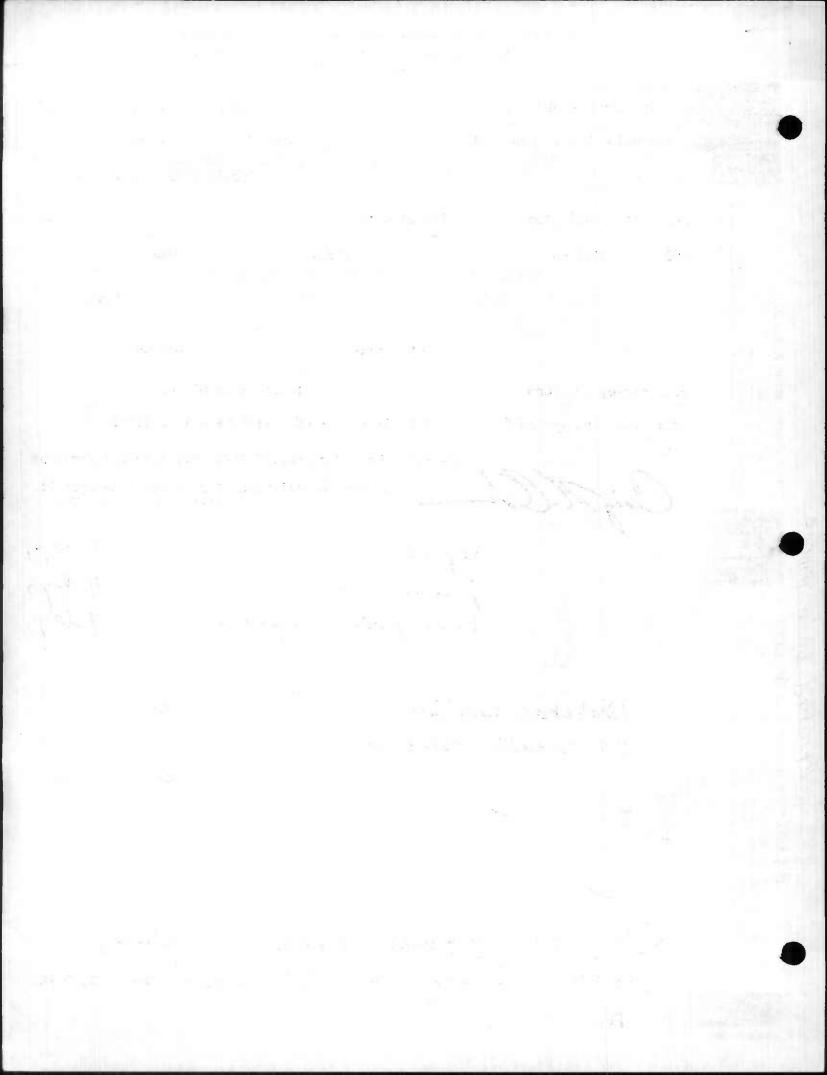
31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture Julia Davidson



State of Maryland / Department of Health and Mental Hygiene

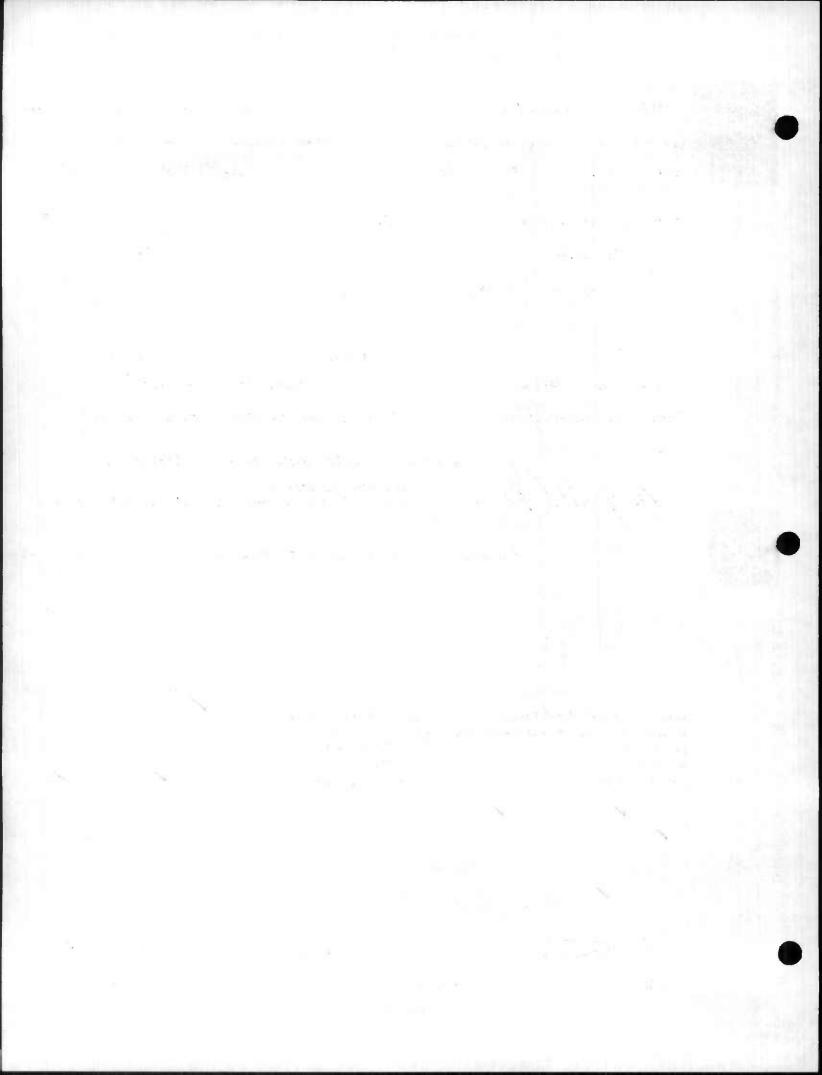
Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Deeth **Physician** Irvin Monroe CRAWFORD.Sr. 450 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1∑ M 2□ F Days 220-16-1618 Yrs. Director Dec. 16, 1923 Maryland Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumetic avent, the Medical Examiner must be notified at 1 Yas 2 No Director Mary land Washington Williamsport 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of Whet Country? ò 8054 Avis Mill Rd. 'natural', or items 23a 21795 USA Funeral Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Ever in U,S. Armed Forcas? 14. Race - American Indien, Bleck, White, atc. filed within 72 hours efter of Hygiene. ther than "natural", or fter 1 Yas 2 No If Yas, Giva Yaer or Detas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Custodian Church permit. Peges 1 and 2 should be filed w
Department of Health end Mental Hygien
Important: If Item 27 is marked other th,
any Injury or other trauments 6 17. Fether's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meidan Sumama) John Wesley Crawford Blanche Edna Miller 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straet end Number or Rural Routa Number, City or Town, State, Zip Coda) Betty Jane Crawford/Wife 8054 Avis Mill Rd. Williamsport, MD 21795 20b. Piaca of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Williamsport, Maryland Greenlawn Mem. Park Feb. 16,1998 21. Signature of Funeral Service Ligerante 22. Nama and Address of Facility 425 S. Conococheague St. Osborne Funeral Home Williamsport, MD 21795 Enter the disaase, or complications that causad tha death. Do not antar tha moda of dying, such as cardiec or respiretory arrest, or heart silure. List only one causa on each line. Approximete Intervel Batween Onset and Death **Physician** da /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner (or as e consequence of); Examiner e runion C Sequentially list conditions, if eny, laading to immediata causa. Entar Undarlying Cause (Disaasa or injury that initiatad evants resulting in daath) Last physician Physician/Medical the Pert II. Other significant conditions contributing to death but not rasulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 | Yes 2 1 No 3 | Probably 4 | Unknown þ 24b. Wera autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Be Completed page 2 20 No 1 Yas 2 No this certificete Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, I 25. Wes casa rafarred to medical 26. Placa of Death (Check only one) Hospitel: 1 hopatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No Certification: To 27. Mannar of Deeth 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 1 CMaturel 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not ba 3 Sulcida 28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 HomicIda 1 Cartifying Phyalcian: To the bast of my knowledge, deeth occurred at tha tima, data and place, and due to the cause(s) and manner as stated. 29a. Cartifiar edical 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the ceusa(s) and mannar statad. 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) U.D. rson who completed cause of daath (Itam 23a) (Type, Print) , un.D COF-31. Deta filad (Month, Dey, Year) State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 7 3 2 5 State of Maryland / Department of Health and Mental Hygiene

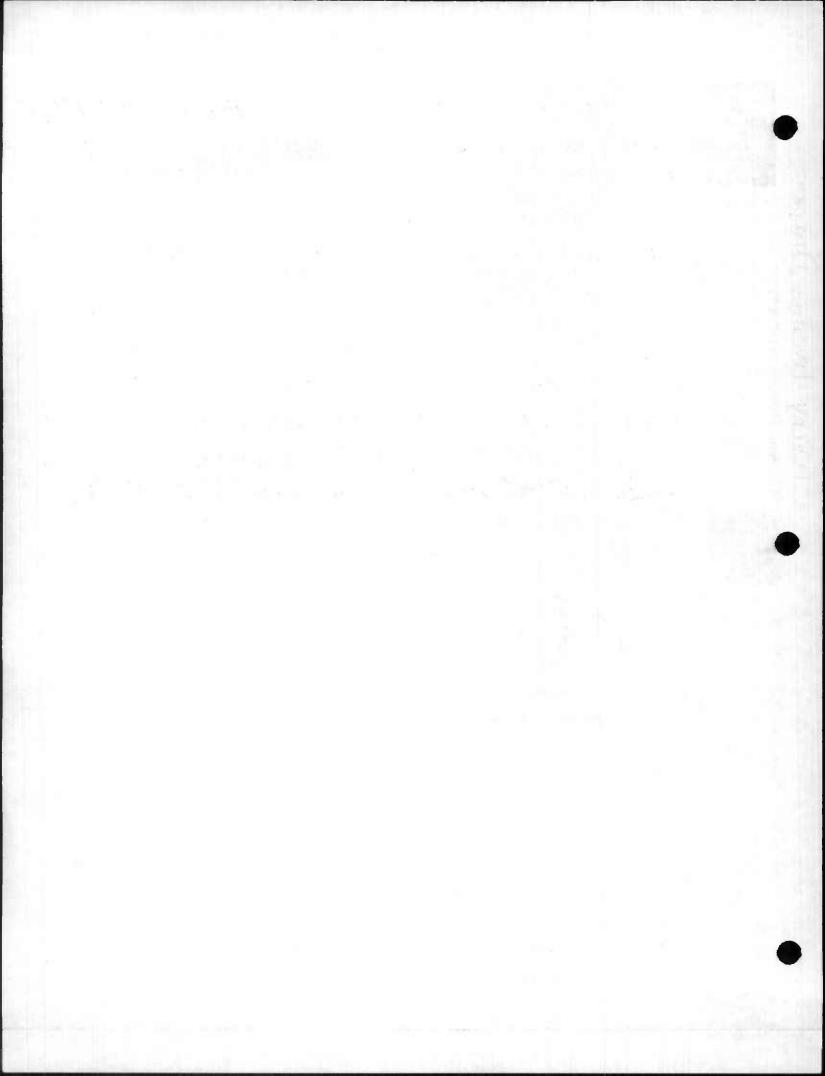
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Marvin Charles DEMORY February 11, 1998 /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 613 Frederick Street Hagerstown Washington Hours Min. 8. Dete of Birth (Month, Day, Year) March 17,1940 5. Social Security Number If Under 1 Yeer 9. Birthplace (State or Foreign Country) Va. 7. Age (In yrs. last birthday) **Funeral** Days 100M 20F 232-62-9242 Yrs 57 Director Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director Washington 1 Nes 2 No Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 613 Frederick Street 21740 USA Неттв 23е death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter of nent of Health and Mental Hygiane.
Int: If Item 27 is marked other than "natural", or ites 1 Never Married 2 Married 1 No services 2 No lif Yes, Give Year or Detes: 1963-1966 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ KNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) manufacturing welder 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lester G. Demory Edith V. Milburn 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health e : If item 27 is or other trace Janice M. Demory - wife 613 Frederick Street, Hagerstown, Md. 21740 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Buriai 2 Cremetion 3 Removel from State permit. Page Department of Important: If any injury or once. Rest Haven Cemetery 2-14-98 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examiner me Due to (or as a consequence of): Examiner The law requires that the death certificate be executed MO and Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician s the burie Physician/Medical Due to (or es e consequence of): 80 980 sete hes been signed by the atter-page 2 should be detached for Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed certificete 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home Certification: To 2 ER/Outpetient 3 DOA 5 Residence 6 Other (Specify) this 27. Mapner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Dete of injury (Month, Day Year) 28b. Time of After Natural 5 Pending Investigation efter death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

(1)

State Registrar

within 24 hours e To the Funeral C completely filled

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

and address of person

Hind Hamdan M 31. Date filed (Month, Day, Year)

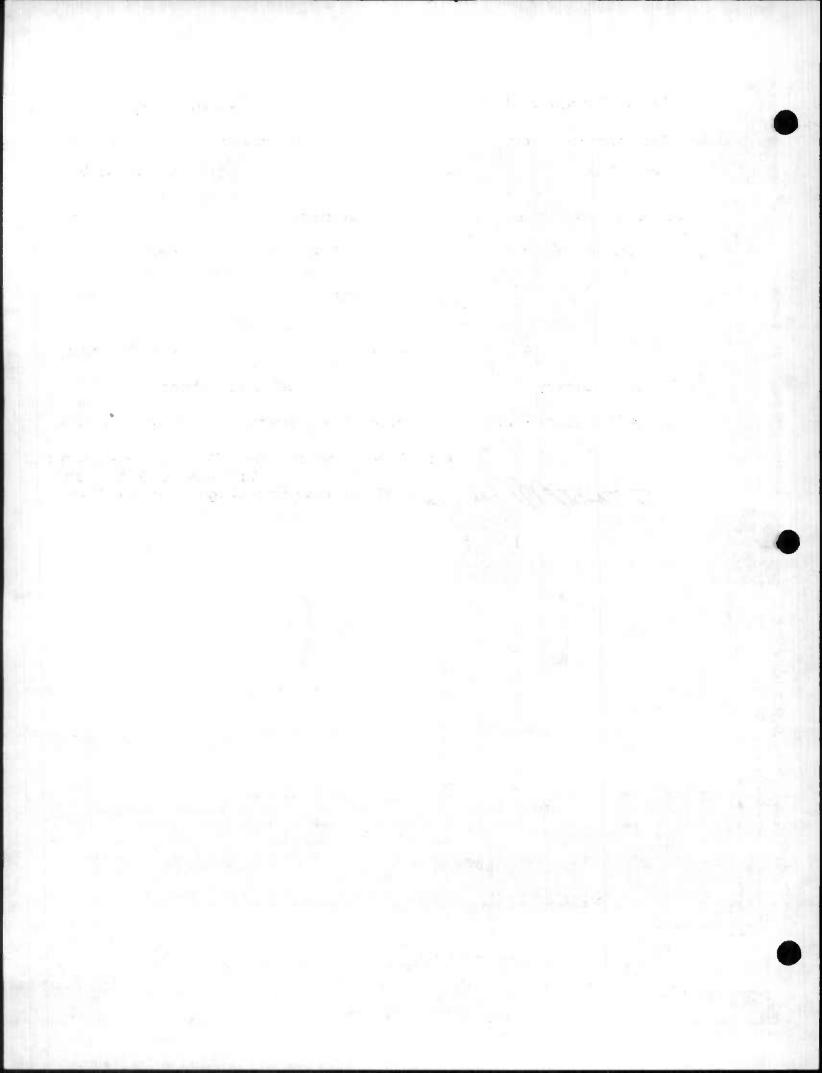
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who completed cause of death (ftem 23a) (Type, Print)

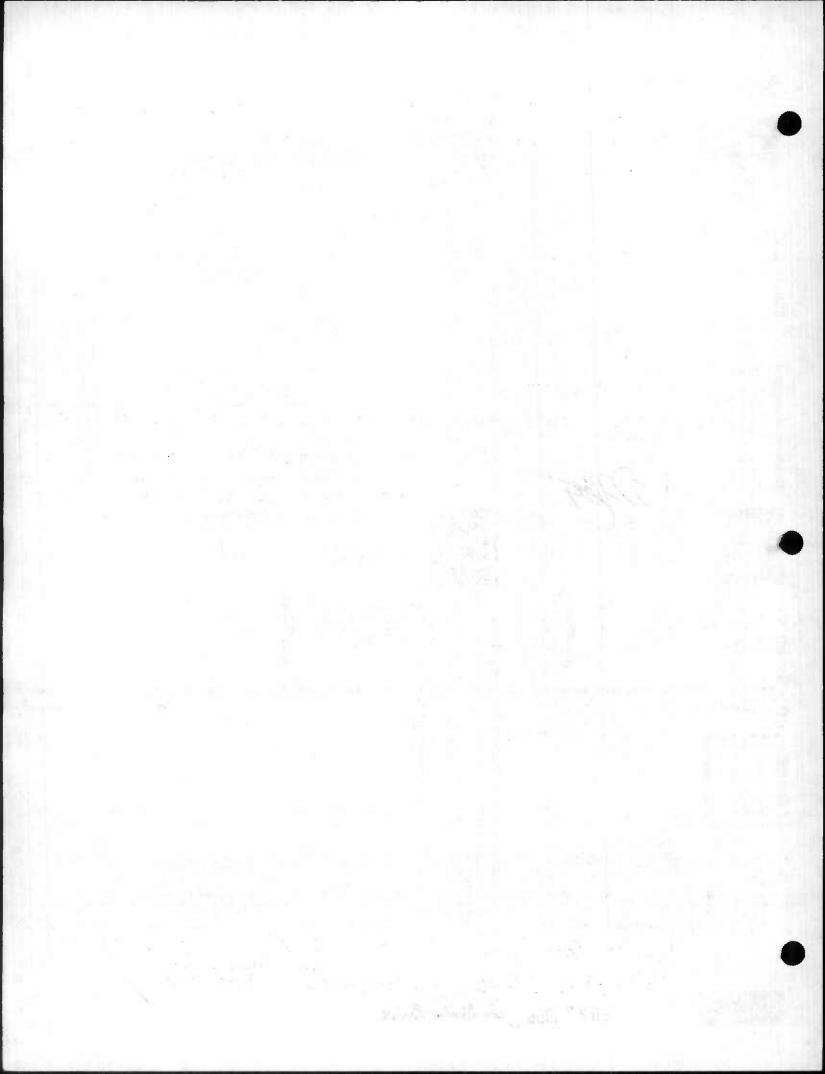
32. Registar's Signature

Hospital



State of Maryland / Department of Health and Mental Hygiene

									tificate of	Death		Reg. No.	8 (17328
В	Physic	ian	Decedant's Nama (First, Mid						ALC:		2. Data of Da Month	aath Day	Yaar	3. Tima of Death
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	Funeral Director		5. Social Sacurity Number 2 2 0 - 1 6 - 4 5 4 3	6. 5	Sax I□M 2KDF	7. Aga (I	n yrs. last bir 91	thday) Yrs.	If Undar 1 Yaar Months Days		(Month, D	rth ey, <i>Year)</i> 1906		placa (Stata or Foraign intry) GINIA
	and *		Usual Rasidanca of Decedant 10a. Stata 10b. Coun	lv		11	Oc. City, Tow	n or Loc	eation					10d Incide City Limits
	f show	5	MD. CARF	•	т									10d. Insida City Limits 1 ☑ Yas 2 ☐ No
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	with a			cm						7		10g. Citizan o		intry?
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21215-0020	filed within 72 hours effer death with the Maryland hygiene. ther than "natural", or items 23a or 28e-f show brt, the Medical Examinar must be nutified at	by Funeral	1 Navar Marriad 2 Ma 3 Widowad 4 Divorce		Armed For 1 Yas If Yas, Gi Yaar or D	orcas? 2X No va	ii ai 0,3.		Yas, specify Cub	Hispanic Orlgin? (Sean, Maxican, Puar Specify:	to Rican, atc.)	Spec	ack, White	
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yla		70	C.F.	ARR	OLL G.	. KII	RBY			MAR	Y E. PI	EARSON		
Jar	CI 0 99 65		19a. Informant's Name/Ralation							end Number or R				
	s 1 end i Health tem 27 i		NANCY K. FLI	ETC	HER -N					N ST.,	WESTMI	NSTER,	MD.	21157
Baltimore,	Pages ment of ant: If it uny or		20a. Mathod of Disposition 1 XBurial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Othar (3 🗆 Specify	Ramoval from	Stata	cemata/	ry, cram	ition (Nama of atory or othar pla TER CEI	ca) METERY2	Data / 23 / 98	20c. Location WESTM		own, Stata ER, MD.
Ball	Depart Import any in		21. Signature of Funesar Service	Lion	neeti				Nama and Addra	I.	LETCHE			HOME D. 21157
	91140	П	23a. Part1. Enter the disease of shock, or heart failure. List	or com	plications that	causad the	death. Do r	1			•			Approximate Interval Batween
	Physician /Medicai Examiner	ner	Immediata Causa (Final disaasa or condition resulting in deeth)		a. V	ent	a to (or es e	ln	Con	line a	nest/	VTo	el l	Onsat and Death 5 mm
	d d ansit	Examiner	Cognecticity that conditions		b	Due Due	to (or as a c	2	anon of):					20 915
68760,	rificete be executed ng physician and es the buriel-transit		Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse, (Disease or Injury that initiated avants	Į	c		to (or as a c						1	V
Вох 68	deeth certifice e ettending ph id for use es th	an/Medical	rasulting in death) Last	Ļ	d		. 10 (0. 40 4 0		41100 017.					
	deed to e	sicia	Part II. Other significant condit	iona co	ontributing to de	eath but no	ot rasulting in	tha und	darfylno causa oiy	van in Part I.	23b. Did	tobacco usa c	ontribute t	o the cause of death?
α,	v requires thet the de been signed by the e should be deteched	by Physician/									10	Yes 2000	3 □ Pro	bably 4 Unknown
Records,	law requires les been sign 2 should be	Completed I									24a. Was	an autopsy omed?	av	dara autopsy findings valleble prior to omplation of causa daath?
E .	sicien: The law s certificate hes t director, page 2 s	Con									1 🗆	Yas 2 No	1	□Yas 2□No
/ita	ysicien: is certific director,	Be	25. Was casa raferred to medica	al						26. Placa of Da	ath (Check only	ona)		
>		2	1 ☐ Yes 2 No		Hospital:	Inpatiant	2 ER/Out	tpatient	3□ DOA Oth	nar: 4 Nursing H	loma 5 ☐ Rasi	danca 6 □O	thar (Specia	fy)
ou	After fune		27. Mannar of Death 1 Natural 5 Pandi 2 Accidant Invast	ng igation		of Injury th, Dey Ye	ear) 28b. T	Ima of njury	M 1	y et		how injury occu		
Divis	al or Atters of the Section of the S	Certification:	3 ☐ Suicida 6 ☐ Could 4 ☐ Homloida detern	not ba ninad	28a. Place	of Injury - ng, atc. (S	At homa, fai pecify)	rm, strea	at, factory, office		28f. Location (City or To	Street and Num wn, Stata)	ber or Run	al Routa Number,
	To the Hospital or Attending Phywithin 24 hours elied deeth, within 27 or the Funeral Director: After thi completely filled in by the funeral	edicai	29a. Cartifiar 1 Certifyi (Check only one) 2 Medical	ng Phy Exam	Nnar: On the ba	best of massis of axa	imination and	, daath o	occurred at tha tin estigation, in my o	ma, data and place pinion, daath occu	, and dua to tha rred at tha tima,	cause(s) end n data and place	nenner as a , and due t	stated. o tha causa(s)
	Veith To t	×	29b. Signature and title of certific	m	delect	2			29c. Licans	a number		29d. Data sign	ed (Month,	Day, Year)
			30. Name and addrass of parson	who o	complated caus	a of death	(Itam 23a) (Type, P	rint)	JOHN 7	niopie	2/15	7	
	Sta Registr	re.	31. Data filed (Month, Day, Yaar FEB 2			ogistrar's	Signatura	Carlo	4				/	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth February 19, 1998 1175 Cornelius Agustus Eyler, Sr. 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Smithsburg 19 Blue Mountain Estates Washington 7. Age (In yrs. last birthday) | If Under 1 Yeer | If Under 24 Hrs. | Months | Deys | Hours | Min. | 5. Social Security Number 6. Sex 1 M 2 F 8. Dete of Birth
June 3, 1922 9. Birthplace (State or Foreign Mary Land 217-16-2398 Usuel Residence of Decedent 10b. Count 10c. City, Town or Location 10d. inside City Llmits Smithsburg Washington 1 Yes 2 No 10f. Zip Code 10a. Citizen of Whet Country? 19 Blue Mountain Estates 21783 USA 12. Wes Decedent Ever in U,S. Agged Forces? 1 Pres 2 □ No If Yes, Give Yeer or Detes: WWZ Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 □ Never Merried 2 □ Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) supervisor Mack Truck 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Clara Virginia McClellan Clarence Henry Eyler 19e. Informent's Name/Reletionship (Type, Print) 19b. Maliing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3492 Turnberry Drive Chambersburg, Penn. 17201 Daughter Moser 20b. Piece of Disposition (Name of cametery, crematory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ₺ Buriai 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Rose Hill Cemetery 2/23/98 Hagerstown, Maryland 22. Name end Address of Fecility Gerald N. Minnich 305 N. Potomac Street Hagerstown, Maryland 21740 Funeral Home 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Instant Due to (or es e consequence of):

Physician /Medical Examiner

physician end s the burial-trans

been signed by the attending should be datached for use as

funaral director.

this

After

i or Attanding satter death. i Director: Att

To the Hospital or Atta within 24 hours after de To the Funeral Directo completaly filled in by the

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital

Examiner

Physician/Medical

by

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Certification:

Medical

Physician

/Medical

Examiner

Director

Funeral

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10a State

Maryland

Sheila

10e. Street and Number

Funeral

Director

with the Meryland

permit. Peges 1 end 2 should be filed within 72 hours after death with the Merylan Depertment of Heelih and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Wed cal Example must be notified at 2008.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting In deeth) Lest

tmmediete Ceuse (Finei disease or condition resulting in deeth)

Pert tt. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No

24e. Wes en autopsy performed?

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

1□ Yes 2 No

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical exeminer?

28e. Date of Injury (Month, Day Year)

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury et Work? 1 Yes 2 No

26. Piace of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

27. Menner of Deeth

1 ANaturel

2 Accident

3 Suicide

4 Homicide

The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 deadloat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier

MD-

29c. License number D45031 29d. Dete signed (Month, Day, Year)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

2 Sipprovi SHAFFAB 31. Dete filed (Month, Day, Year)

5 Pending

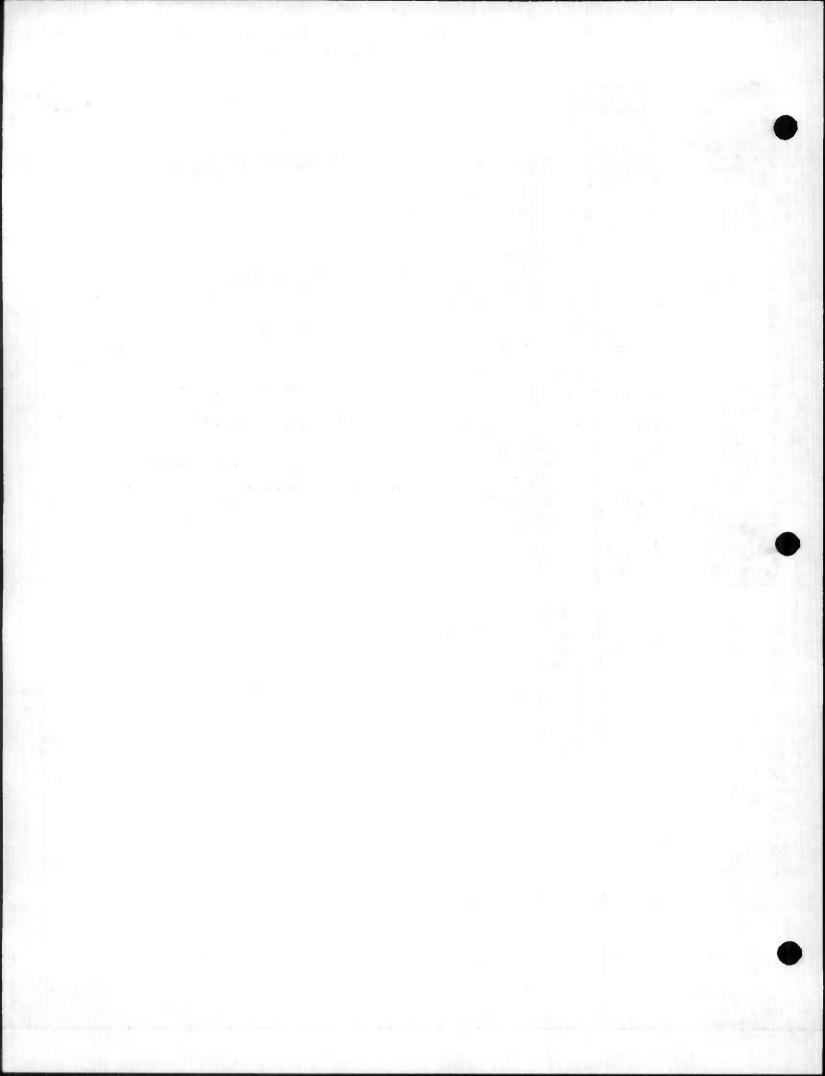
investigetion

6 Could not be determined

19414-C 1817 (205 BORG PE HAGERS TOWN MD 21742

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 4b. City, Town, or Location of Daath 4c. County of Death CHARLES BALIENT FAULHABER 400 4a. Facility Nama (If not institution, giva street and number) Washington County Hospital Hagerstown Washington if Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) July 20, 1906 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1□XM 2□ F Yrs 066-01-4894 91 Hungry Usual Rasidanca of Dacadant 10a Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 1 XYas 2 No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 141 South Main Street 21713 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 X Yas 2 No If Yas, Giva Yaar or Detas: WW II 1 Nevar Married 2 Marriad 1 Yas 2 No Specify: White 3 Widowad 4 Divorced 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decadant's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting Contractor 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Faulhaber Adam Frances (Unknown) 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Numbar or Rural Route Number, City or Town, Stata, Zip Code) A. Louise Faulhaber 829 Armstrong Avenue, Hagerstown, Maryland 21740 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Spacify) Cedar Lawn Memorial Park 02-20-98 Hagerstown, Maryland 21. Signatura of Funaral Sarvica Licansaa Andrew K. Coffman Funeral Home, Inc. R. hall Brady 40 East Antietam Street, Hagerstown, Md. 21740 23a. Pert1. Entar tha disaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart feilure. List only one cause on each line. Immedieta Ceuse (Finel disaasa or condition rasulting in death) Phennania 1 mach Dua to (or es a consequence of): Sequantially list conditions, if any, laading to Immadiata causa. Enter Underlying Causa (Disease or injury that initiated evants rasulting In death) Last Dua to (or as a consequence of): Dua to (or as a consequence of):

Physician /Medical Examiner be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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"natural",

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "na any Injury or other traumstic event once.

Directo

Funeral

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Completed

Be

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traumatic event, the Medical Examiner must be notified at

filed within 72 hours efter death

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

+06/463

Gultabor, Charles

The lew requires that the death certificete

Examiner ettending physician end for use es the buriel-transit Physiclan/Medical signed by the etter ρ should should Completed r this certificate hes Be Certification: To e Hospital or Attending Physin 24 hours efter death.
Funeral Director: After this of Puneral Director director

Part II. Other significant conditions of	ontributing to death but not re		g causa givan in Part I.	23b. Did tobacco use cor	atribute to the cause of death
Cardinarader	Dinen &	Hybermen	Diren	24a. Was an autopsy performad?	24b. Wara autopsy findings available prior to completion of cause of death?
				1 ☐ Yes 2 ☐ NO	1 ☐ Yas 2 ☐ No
25. Wes casa referred to medical axaminar?			26. Placa of De	aath (Check only ona)	
1 Yas 2 No	Hospitel: 1 inpatiant 2	☐ ER/Outpatiant 3☐	DOA Other: 4 Nursing	Homa 5 ☐ Residence 6 ☐ Othe	ar (Specify)
27. Mannar of Death 1 Natural 5 Pending 2 Accident Invastigation	28e. Deta of Injury (Month, Day Year)	28b. Tima of Injury M	28c. Injury at Work? 1 Yas 2 No	28d. Dascribe how Injury occurr	bed
3 Sulcida 6 Could not b 4 Homlolda datarmined		noma, farm, straat, fact	ory, office	28f. Location (Street and Number City or Town, Stata)	er or Rural Routa Number,
				ce, and dua to tha causa(s) and ma curred at tha tima, data and place, a	

State Registrar

Dalla

D(8019

29c. Licansa number

29d. Data signad (Month, Day, Year) Feb 19 1998

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

water mo

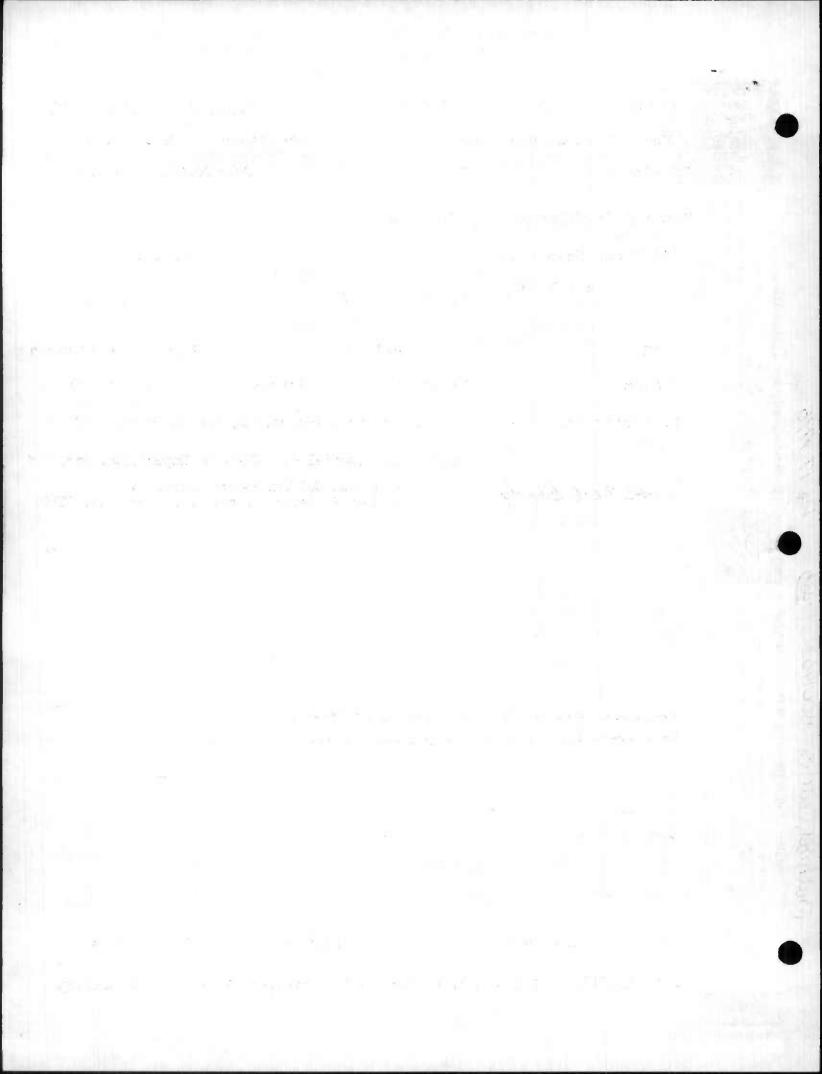
29b. Signatura and title of certifiar

31. Data filed (Month, Day, Year) 1998

334 m, 11 Street 32. Ragistrar's Signatura

Hagerstown Maryland

To the Hospital within 24 hours e To the Funeral Completely filled



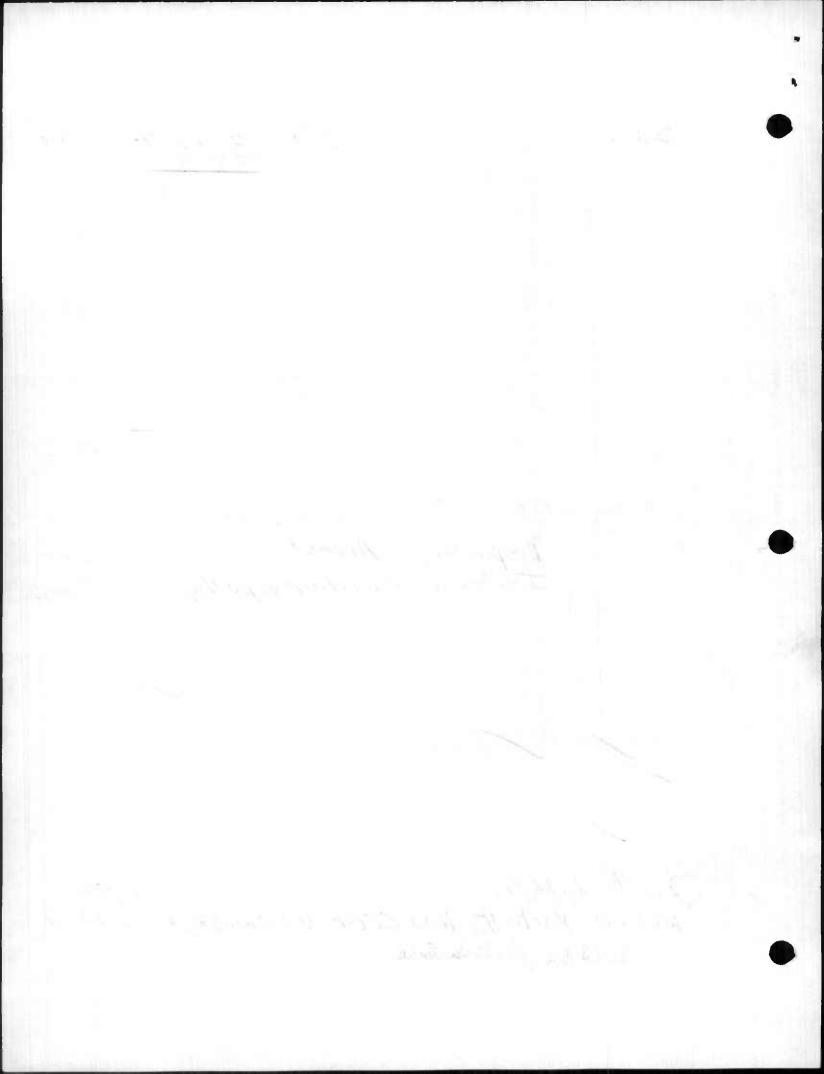
FEB23

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH -OX Earl 10:00 4. SOCIAL SECURITY NUMBER 5. SEX NOW th, 12 per) 1918 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 1 M 2 - F 238-03-5408 NC permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR Carroll County General Hospita. Westminster Cannoll 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MA Cannoll Westminster 1 YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7 Chase Street for use as the burial-transit 21157 United States retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf was specify Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, While air. 1 Never Married 2 Merried If yes, specify Cuban, Mexican, Puerto Rican

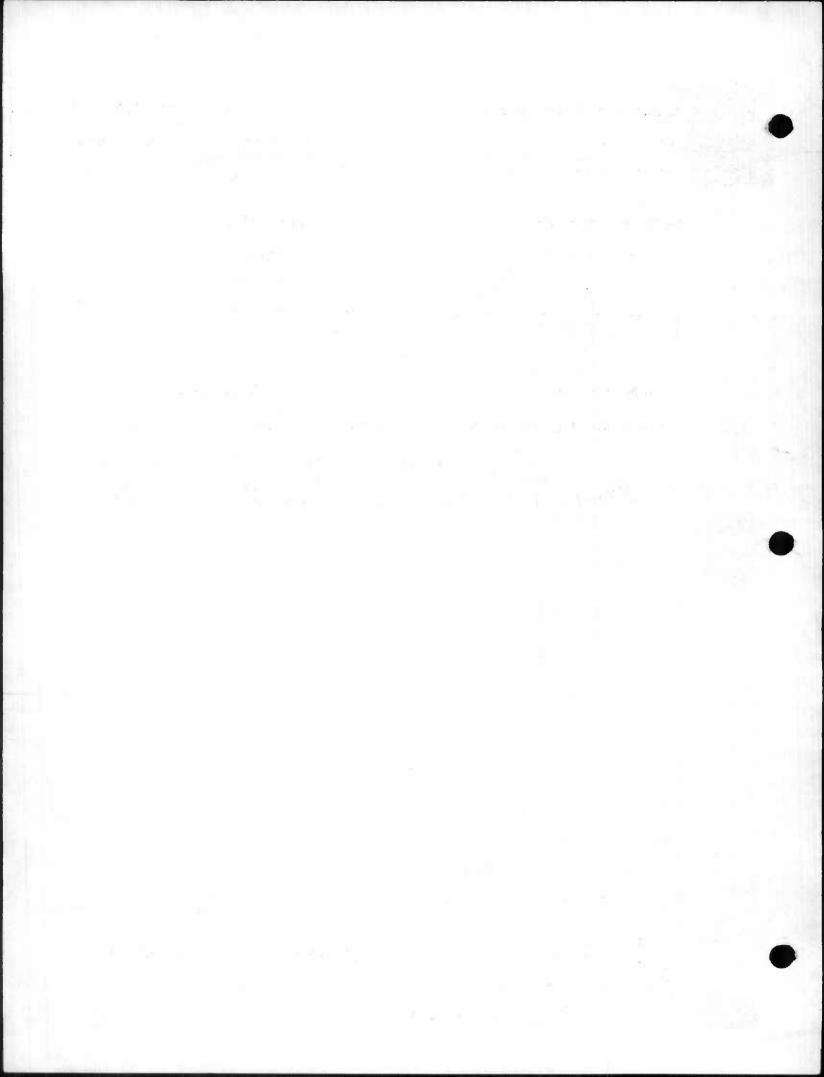
1 YES 2 NO Specify: BY 3 Widowed 4 Divorced white WWII COMPLETED 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only his (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) machinist Bendix-Freise 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surneme, Thomas Fox क Opha Robinson page 5 should be BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chase Street, Westminster, MDX MD Hazel Fox, urs after death. Page 6 may be 9 20e, METHOD OF DISPOSITION
1 A Burlel 2 Cremetion 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name 2/25/98 DATE 20c. LOCATION — City or Town, State funeral director, Forest Veterans annison Owings Mills. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel Kathering Paits - Sweiter 412 Washington Rd. Wes 23. PART I. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Westminster. medical filled in by Approximate shock, or haart fallure. List only one cause on sech intarval Batween **IMMEDIATE CAUSE (Final** Onset and Daath the disease or condition Dirator Smin resulting in daath) executed within event, Tardio myopathy COM burial, traumatic CERTIFICATION and Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF). if any, leading to immediate cause. Enter UNDERLYING attending physician ntal Hygiene prior to OR ATTENDING PHYSICIAN: The law requires that the death certificate be prior other t CAUSE (Diseasa or Injury OUE TO (OR AS A CONSEQUENCE OF) DIVISION OF VITAL RECORDS, P.O. that initiated events resulting in daeth) LAST ō PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS and AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any signed Health a 1 TYES 2 THE f. of H 1 YES 2 NO PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? Item 26. PLACE OF DEATH (Check only one) certificate f or this cer.

with the Sta. OTHER: 1 YES 2 NO ntlant 2 - ER/Outpetlent 3 - DOA ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY marked, 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO DIRECTOR: After the hours after death vitem 28 is mart BY 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, lactory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner se stated. TO THE FUNERAL DE filed within 72 h 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Morgin, Day, Year)

2/19/98 29c. LICENSE NUMBER BE D39296 2 LETEO CAUSE OF DEATH (ITEM 27) (Type, Print) 200 Memorial Avenue -icke ober Westminste 31. DATE FILED (Month, Day, Year) 32. REGISTRAP'S SIGNATURE



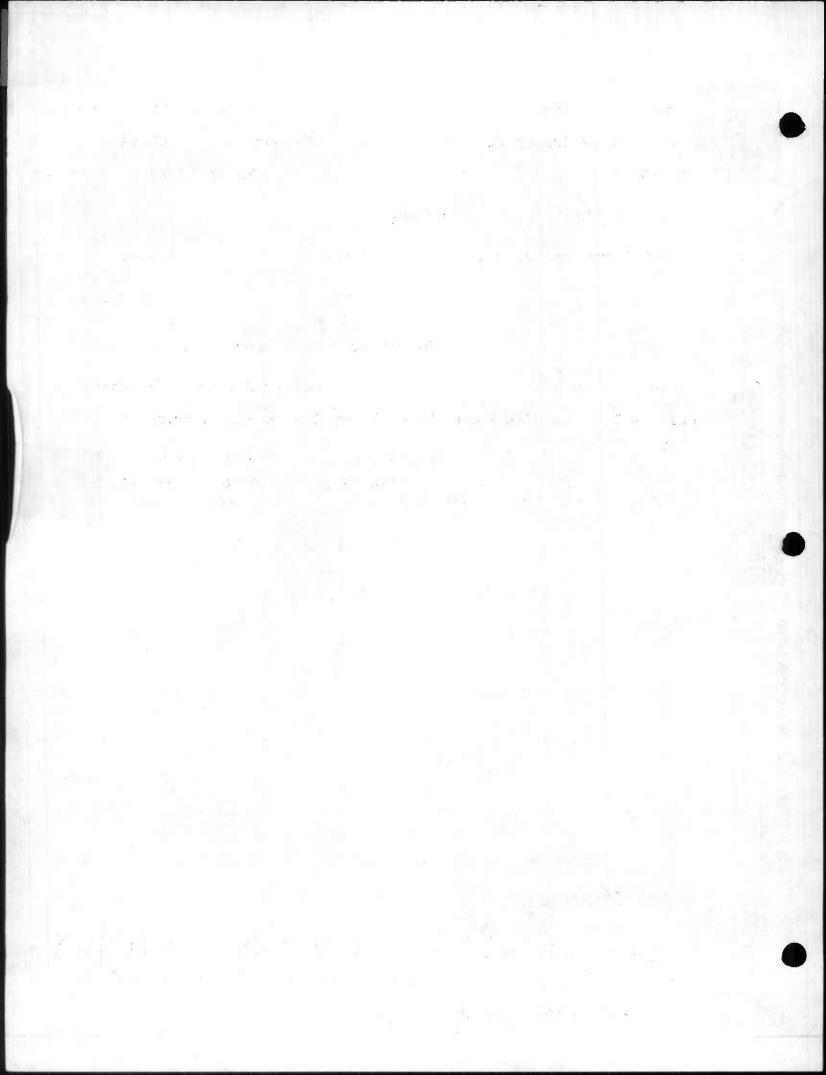
				•		ificate of	Death		Reg. No.	U	/332
Physic /Medi		Decedent's Neme (First, Middle, Last Elizabeth Mary	Gunnin					2. Dete of De Month Feb.	Dey 17, 19	Yeer 98	3. Time of Deeth
Exami		4e. Fecility Neme (if not institution, give	street end numbe	er)			4b. City, Town, or L		4c. County	of Death	
<u> </u>		120 Carroll Road					Stevensv		~	en An	
Funeral Director		5. Sociel Security Number 6. S 218-03-0963 1 Usuel Residence of Decedent	ex 7.7 □ M 2√2 F	Age (in yrs. iest	Yrs.	If Under 1 Year Months Deys	if Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, De Mar 5,	h y, Year) 1920		lece (Stete or Foreign try) Land
inyland show		10e. Stete 10b. County		10c. City, T	own or Loca	ation				1	0d. Inside City Limits
Sa-f.	cto	Maryland Queen A	nnes				Stevensvi	lle			1 ☐ Yes 2 € No
th with th	Funeral Director	10e. Street and Number 120 Carroll Road				10f. Zlp Code	21666		10g. Citizen of W	/het Coun JSA	itry?
is 1 and 2 should be filed within 72 hours after death with the Maryland if Haalth and Mental Hygiena. I have 71 is marked other than "natural", or items 23s or 28s-1 show other traumatic avant, the Medical Examples must be notified at	by Fune	11. Maritel Stetus 1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Wes Deceder Armed Force: 1 ☐ Yes 2 ⊈ If Yes, Give Yeer or Dates	s? 【 No		es Decedent of H Yes, specify Cubi	lispanic Origin? (Sp en, Mexican, Puerto Specify:	pecify Yes or No Ricen, etc.)	14. Rece Bleck	k, White,	an indien, etc. Thite
od within 72 hours afr giena. er than "natural", or the Medical Exam	Completed	15. Decedent's Ec (Specify only highest gra Elementery/Secondery (0-12)	ucation de completed) College (1-4o		life. Do	ent's Usuel Occup ind of work done O NOT use retired		sing	16b. Kind of Bu	siness/Inc	dustry
filled v Hygie other t		17. Fether's Neme (First, Middle, Last)			Cust	Collet Se	18. Mother's Nem	o /First Middle			
d 2 should be filed within the and Mental Hygiena. The marked other then traumatic avent, the	To Be	Ralph Theodore	Mister					eth Bie		θ)	
2 should and Men is marks sumetic		19e. Informent's Neme/Reletionship (7	ype, Print)	1	19b. Melling	Address (Street	and Number or Rui	rei Route Numbe	er, City or Town,	Stete, Zip	Code)
Haalth Harm 27 i		William Gunning,	Sr, Hush				Rd, Steve	nsville	, MD 216	566	
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s law requires has been sign pe 2 should be	Completed t	0	0		-			24a. Wes perfo	en eutopsy med?	600	ere eutopsy findings elleble prior to mpletion of cause death?
0 - 0	Com							101	es 2000	1 🗆	Yes 2□ No
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Physician: this carific rat director.	To	1 ☐ Yes 2. No	Hospitel: 1 Inpa	tient 2□ER/	Outpatient	3□ DOA Oth	4 Li Nursing Ho	ome 5 Resid	lence 6 Othe	r (Specif)	1)
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al or Attend s after death d Director: ed in by the	Sertific	3 Suicide 6 Could not be determined	286. Piece of I	njury - At home, etc. (Specify)	, ferm, stree	et, fectory, office		28f. Location (5 City or Tox	Street and Numbern, Stete)	er or Aura	i Route Number,
To the Hospital or within 24 hours at To the Funeral DI completely filled in	edical C	29e. Certifier (Check only one) 1 Certifying Phy	reicism: To the besiner: On the besis end menner s	of exemination	ige, deeth o end/or inve	occurred at the tin stigetion, in my o	ne, dete end plece, pinion, deeth occur	end due to the ored et the time,	ceuse(s) end msi dete end plece, a	nner as st and due to	eted. the cause(s)
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		30. Name end eddress of person who o				rint)		40.0	•	10	
000	1000	31. Dete filed (Month, Dey, Year)	1 32 Ranks	E. MA	. 11- الم	STEVE	WSVILLE	MS UL	.L &		
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				State C	or Maryla		artment of F			R	eg. No. 9	3 6	7333
cian		Name (First, Mid								2. Date of Deal Month	n Day 2 1998	Year	3. Time of Death
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ai	5. Social Sacu	-	6. Sax			s. last birthday,	If Under 1 Year	If Under a		B. Date of Birth (Month, Day		g. Birth	piace (State or Foreig
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Funeral Director	11. Marital Sta				edent Ever in	U,S. 13.	Was Decedent of H	lispanic Ork	gin? (Spec	ify Yas or No-	14. Rac		can Indian,
F	1 Naver	Married 20 Ma	rried	1 Yas	2 NO		1 ☐ Yas 2 ☐ No	Spacify:	i, Puarto n	ican, atc.)		y: Wh	
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lete		15. Decede Specify only high				16a. Dece	dent's Usual Occup kind of work done DO NOT usa retire	pation during most	t of working	g	16b. Kind of B	usiness/In	ndustry
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To B	John	Blanker	nshi	P				Kels	sey I	Prater	Blanl	kens	hip
		it's Name/Relation					ing Address (Street						
	Franci	s T. Ha	ayde	n/Hus			0 Perry	Bran	ich l	kd. Ne	wburg	, MD	20664
	20a. Method o	f Disposition i 2 □ Cremation	3 □B(emoval from		Place of Disp cemetery, cre	osition (Name of matory or other pla	ce)			20c. Location		own, State
	4 Dona	tion 5 Other (Specify)		Но		ost Cem		3/5/		Issue		
	21. Signature	of Funeral Service	License	a of t	1	Å	REHART -	ECHOI	S FU	JNERAL	HOME	,PA.	
	1	tovid (0	Nex	d	945 P	.O. Box	567	LaP	Lata,M	D 206	46	
Medical Examiner	Sequentially i if any, leading causa. Entar Cause (Disea that initiated e resulting in de	ist conditions, to Immediate Underlying se or injury events ath) Last	{ .	M		(or as a conse		Cun	A	1500	Q), \	وبال	23100
Physician/M	Part II. Other s	algnificant condit	ions cont	tributing to d	eath but not re	esuiting in the u	underlying ceuse giv	ven in Part I.		23b. Did to	becco use co		to the cause of deat
by F													
Completed							_			24a. Was a perform		a\ cc	lere autopsy findings vailable prior to empietion of cause death?
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2	1 Yes	2 No	H	1	-	ER/Outpatie	nt 3LI DOA			a 5 Resid			ify)
lon	27. Manuer of	l 5 ☐ Pend		28a. Date (Mon	th, Day Year)	28b. Time of Injury		ryat rk? Yes 2∐!		3d. Dascribe h	ow injury occur	rred	
Certification:	2 ☐ Accide	te 6 Could		28a. Place	of Injury - At	homa, farm, st	reat, factory, office	163 201		Bf. Location (S	treet and Numi	ber or Rur	ral Route Number,
ert	4 🗆 Homi	cide deter	mined	buiidi	ng, etc. (Spec	eify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town	n, State)		
edical C	29a. Certifier (Check on one)			er: On the b			th occurred at the timestigation, in my o						
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7	1	2 m	10	70	WIL		()	20	62	9	5	U	(1X)
	30 Name and	address of perso		npieted caus	se of death (Ite	em 23a) (Type	, Print)	00	0	100		C 100	2000
	George	100		ID 11:	345 Pe	embroo	ke Squa	re Su	uite	103 W	aldor	i,MD	20603
ite	31. Data filad	(Month, Day, Yaa	r)	32. F	Registrar's Sign	nature							

Registrar

MAR 0 4 1998 Julia Stevelson Randoll



DON HUGHES

Physic /Medi Exami

Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Cartificate of Death

Baltimore, Maryland 21215-0020		
	/Me Exa	sician edicai miner
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter deeth.	To the Funeral Director: After this cardificata has been signed by the ettanding physician and completaly filled in by the funeral director, page 2 should be datached for use es the buriel-transit

1. Decedent's Name (First, Middle, L Dan Hous	ston	Hugh	es, I	I			4	2. Date of Month FEB.		о ^{еу} 1998	8 ^{Year}	3. Time	7 AN
Aa Facility Name (If not institution, gi PRINCE GEORGES			ER		4	b. City, To CHEV		ocation of D	eath	4c. County PRIN		EOGES	
	Sex 1MM 2□F	7. Age (In yrs. 61	last birthday Yrs.	Months I	Yaar Days	If Under Hours	24 Hrs. Min.	8. Dete of (Month)	Birth Day, Yes	1936	9. Birthp	piace (State	or Foreig
Usual Residence of Decedent 10a. Stele 10b. County			y, Town or L									IOd. Inside (
Va. King	George	e K:	ing G	eorge								1 ☐ Ye	2 M N
10e. Street and Number 16171 Trigge	r Lane	9		10f. Zip C		248	5		10g. (U.S.		ntry?	
11. Marifal Status 1 Never Married 3 Widowed 4 Divorcad	12. Was Dec Armed Fo 1 Yes If Yes, Gi Yeer or D	2 No	,S. 13.	. Was Deceder If Yes, specify	37	spanic Or n, Mexica Specify		pecify Yes or Rican, etc.	No-		k, White,	can Indien, efc.	
15. Decedent's E (Specify only highest gi	ade completed)		16e. Dece (Give	edent's Usual (e kind of work DO NOT use	Occupe done d retired	etion during mos	st of wor	king	16b.	Kind of Bu	usiness/Inc	dustry	
Elementary/Secondery (0-12)	College (1-4or 5+)		lding					N	lewsp	ape	r	
17. Fether's Name (First, Middle, Las)							ne (First, Mic	ldle, Meid	len Sumem	10)		
Dan Houston	Hugher	s, Sr.				Be:	rnie	ce St	ickl	and			
19a. Informant's Name/Relationship	(Type, Print)		19b. Mail	ling Address (S	Street e	end Numb	er or Ru	ral Route Nu	ımber, Cit	y or Town,	Stete, Zip	Code)	
Mary C. Hughe	s (Wi	fe)	161	71 Tr:	igg	er l	La.	King	Geo	rge,	Va	. 224	85
20a. Method of Disposition			Place of Disp	oosition (Neme ematory or othe	of er pleci	a)		Date	20c.	Location -	City or To	own, State	
1 XBuriei 2 ☐ Cremetion 3 € 4 ☐ Donation 5 ☐ Other (Spec		State T:	rigge	r Fam:	ily	Cer	n. 1	2/27/	98 K	ling	Geo	rge.	Va.
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ywit-	10	11 , 1	1	Nash &	c s	law	F. 1	I. Ki	no C	enro	70. 1	Va.	
23a. Part / Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Finel disease or condition	policetions that one ceuse on	caused the seet		Nash a						Georg	ge, '	Approximintervel Bronset and	tween
Immediate Cause (Finel	e	caused the seet seet line.								eorg	ge, \	Approximatintervel B	tween
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State Registrar

31. Dete filed (Month, Dey, Yeer) FEB 2 6 1998 32 Registrar's Signature

E.M. Foreton United States of the State States of the Stat

Bulleton Services Newspaper

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Two Houston Hughes, Fr. Baraice Sticklers

Mary C. Aughas (Mica) 5:70 Trisger La. Ming George, 'A. 22AFS

Triguer Family Com. 2/27/98 King George, Va.

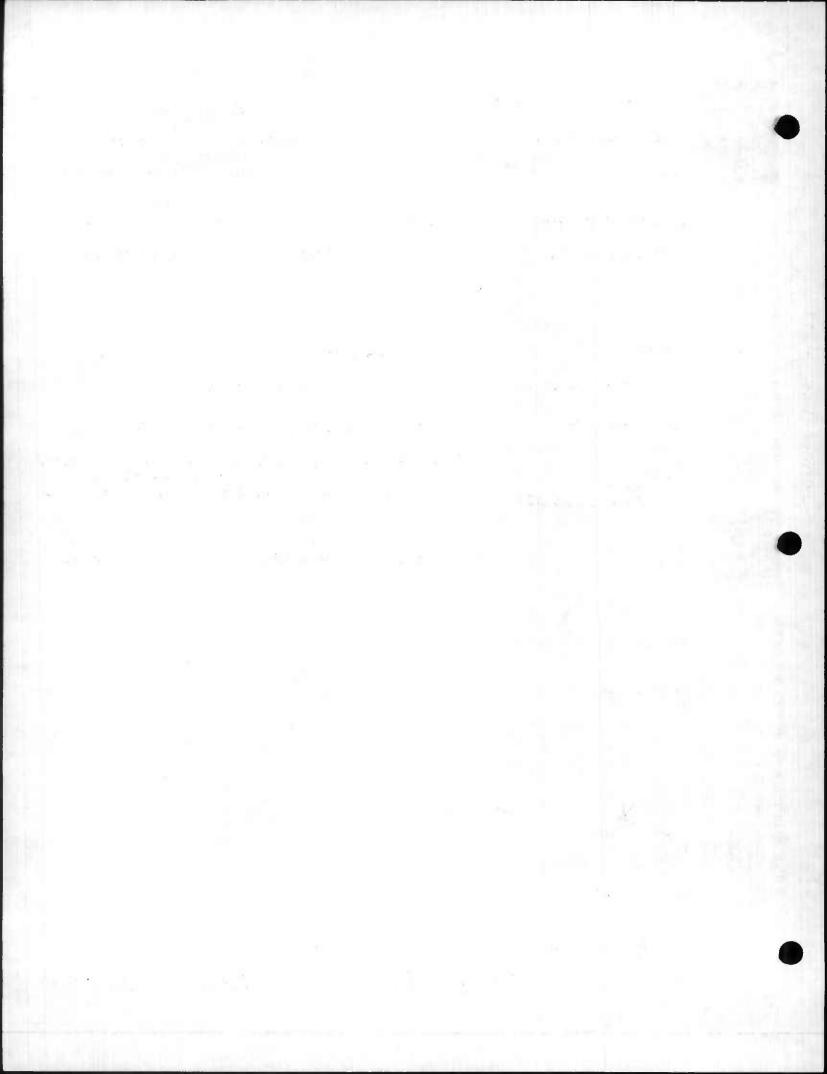
Nuch & Slee F.M. Ming Coorse, V.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Month ZZ 2020 1 enne lec rebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 7. Age (In yrs. lest birthday) if Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days 214-34-2398 85 Yrs Director August 10, 1912 Maryland Usual Residence of Decedent the Marylend worle 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or items 23a or 28a-f ehor other traumatic event, the Modical Excitans must be notified at 1 Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1098 Marshall St. 21740 United States 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, atc. permit. Pages 1 end 2 should be filed within 72 hours efter. Department of Health end Mentel Hygiene. Important: if Itam 27 is marked other than "natural", or ther any Injury or other traumatine event. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: White 3 ☑ Widowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grede comp 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry rede completed) Elementary/Secondery (0-12) College (1-4or 5+) Unknown Homemaker Her own 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be David F. Staley Mary S. Palmer 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Betty Jane Huff 1098 Marshall St. Hagerstown, Md 21740 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2-25-98 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Fred LiVestal 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dylng, such es cardiec or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Onset and Death **Physician** /Medical Immediate Cause (Final Test cereprovalculus accident disease or condition resulting in death) 2 wks Examiner Due to (or as a consequence of) Examiner iclan and burief-transit Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): physiclan s the buriel Box 68760 2 Physician/Medical Due to (or as a consequence of) attending pl signed by the aid be deteched for P.O. Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an eutopsy performed? Completed peen page 2 : hes certificate. 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA To Other: 4 Nursing Home 5 Residence 8 Other (Specify) this funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of or Attanding Peter death. Certification: 5 Pending invastigation Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Straet end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled edicai 29a. Cartifian 🔀 Certifying Phyalcian: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yaer) 2)25/92 mo mousomo D47234 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Hagerstown Maryland Strouss lorth Huenve 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State FEB 2 5 1998 ulia Lavidson Bandall. Registrar

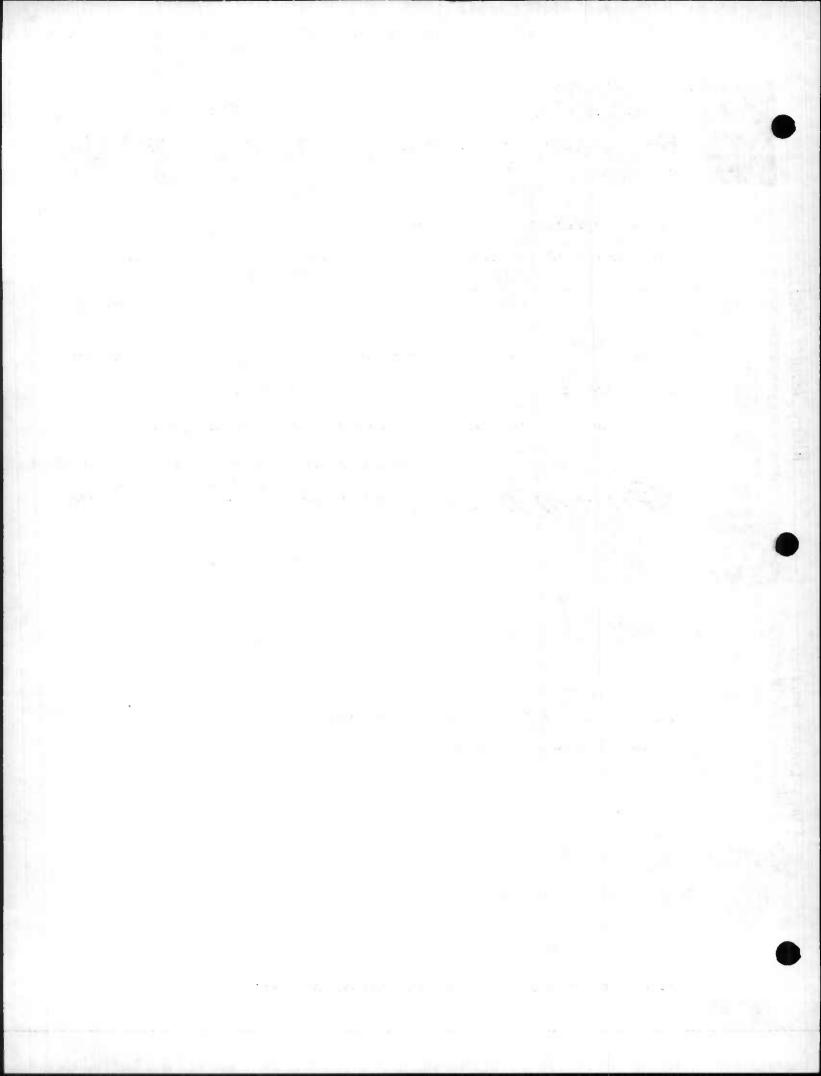
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State of Maryland / Department of Health and Mental Hygiene

			Decedent's Neme (First, Middle, Last	o.f)		Ce	rtifica	ate of	Death	2. Dete of D	Reg. No.	0 0	3. Time of Deeth
	Physic /Medi		Mary Louise HU	LL						Month Feb,	Dey 22	1998	7 55 pm
	Exami		4e. Fecility Neme (If not institution, give) ,				4b. City, Town, or	4	th 4c. Co	unty of Deetl	n
			Fahrney-Keed		rial	Home			Boones	boro		lashir	noton
-	Funeral		5. Social Security Number 6. S	ex 7.A □M 2DXF		. last birthday)	Month	der 1 Year s Deys	if Under 24 Hrs. Hours Min.	8. Dete of Bi (Month, D	rth ey, Year)	9. Birtl	halace (State or Foreign
	Director		214-09-8638 Usuel Residence of Decedent		77	Yrs.				June	5, 1920) Mar	yland
	be filed within 72 hours efter death with the Merylend tell Hygiene. d other than "natural", or items 23e or 28e-f show event, tre Mexical Examiner must be notified at		10a. Stete 10b. County		10c. Ci	ity, Town or Lo	ocation						10d. Inside City Limits
	Ne Me	Director	Maryland Washing	ton		Hager	stow	n					1 ☐ Yes 2 🏋 No
	er 2	Dire	10e. Street end Number				10f.	Zip Code			10g. Citizen	of What Co	untry?
	23a		14214 Paradise Ch					217			U.S		
_	er de	Funeral	11. Maritel Status	12. Wes Decedent Armed Forces	3	J,S. 13.	Was De	cedent of F becify Cubi	lispenic Orlgin? (S en, Mexican, Puert	pecify Yes or N o Ricen, etc.)	0- 14.	Race - Amer Bleck, White	
Hu]	72 hours effer death with the Meryle "natural", or Rems 23a or 28a-f show kildal Expringer must be notified at	by F	1 Never Merried 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give Yeer or Detes:			1 🗆 Yes	2 💢 No	Specify:		Spe	ecify: Wh	nite
Hu 5-0020	2 hou		15. Decedent's Ed	lucetion		16e. Dece	dent's U	suel Occup	pation		16b. Kind o	of Business/I	
215	within 72 ho iene. 'than "natur ore Medical	Completed	(Specify only highest gra Elementery/Secondery (0-12)	de completed)	E.V.	(Give	kind of DO NOT	work done use retired	during most of word)	rking			,
15	jene. r than	EO	0-12	College (1-4or	5+)	Home	make	r			He	r own	home
Ouise ind 2121	be filed that Hygie d other event, to	BeC	17. Fether's Neme (First, Middle, Last)						18. Mother's Ner	ne (First, Middle	, Maiden Sur	name)	
1 Lou aryland		To	Earl K. Mentzer						Mabe1	В.			
lan	d 2 should th and Mer 7 Is marke traumatic	ľ	19e. Informent's Neme/Reletionship (7	Type, Print)		19b. Meili	ing Addre	ess (Street	end Number or Ru	ural Route Numi	oer, City or To	wn, Stete, Z	ip Code)
N. S	D S L		Joan L. Coblentz	- Daughte					k Ave.	Mt. Air	y, Md.	21771	
Mary altimore, N			20a. Method of Disposition 1X Buriel 2 ☐ Cremetion 3 ☐	Dames of free Chate	20b. I	Plece of Dispo	osition (A	leme of r other ple	ce)	Dete	20c. Locati	on - City or	Fown, State
F F	Pages nent of I ant: If ite ury or o		4 □ Donetion 5 □ Other (Specify			st Have	en C	emete	ry 2	-25-98	Hager	stown.	Maryland
a t	permit. Pages Department of Important: If ite any injury or of		21. Signeture of Funeral Service Licen	000	in.				on of English	innich			
ω	Depa Impo		Darto	man		1 4	15 E	. Wil	son Blvd		rstown		
2 4 4			23e. Pert1. Enter the disease, or comp shock, or heart feilure. List only	olicetions that cause	d the dee							,	Approximete
	Physician		SHOCK, OF HEART HEIRIGHE. LIST OFFINE	one cease on eech	iirie.							1	Intervel Between Onset end Deeth
	/Medical		Immediate Cause (Final disease or condition		PAS	roll	Ca	a Carra	0134	Lune		1	6 maths
	Examiner		resulting in death)	е		or es e consec							
	₽ #	Iner										1	
	ifficete be executed g physician end es the bunel-transit	Examiner	Sequentielly list conditions,	D. —	Due to (or es e consec	quence o	f):					
30,	cian cian		Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury	•									
68760,	physic s the b	edical	thet initieted events resulting In deeth) Lest	0.	Due to (d	or es e conseq	quence o	f):					
				d								1	
= Sox	ath c	lan		ŭ.									
Hα.O.	requires thet the death cent een signed by the ettendin hould be deteched for use	by Physician/N	Pert II. Other significant conditions co	ontributing to deeth t	but not res	sulting In the u	inderlyin	g cause giv	ven in Pert I.	23b. Dfd	tobacco usa	contributa	to the cause of death
0	d by	F.	brain tuma 1	Anterior as	dert.	T GN	ndi e	m2160	un	1 🗆	Yes 20 N	lo 3 Pr	obably 4 Tonknow
Se de	signe 1 be of										in a contract	1	
Lawise Records, F	been si	Completed	airem Parte	man Din	un					24a. We	en eutopsy ormed?	e	Were eutopsy findings evelleble prior to completion of ceuse
Q S	lav 188	nple										c	of deeth?
_	Pag at	S								10	Yes 2DN	5 1	Yes 2 No
Zit-	clan:	Be	25. Wes cese referred to medical exeminer?	11					26. Plece of Dee	eth (Check only	one)		
Mary of Vita	Physic this c	2	1 165 ZE NO			ER/Outpatier			4 Libertuising n	lome 5 ☐ Res			ify)
2 -	fe fe	inol in	27. Menner of Deeth 1 ☐ Naturel 5 ☐ Pending	28e. Dete of Inju (Month, Da	ury ay <i>Year</i>)	28b. Time o Injury		28c. Injur Wor		28d. Describe	how Injury or	curred	
Sic	deeth. ctor: A y the fu	cat	2 Accident Investigation 3 Suicide 6 Could not be				М		Yes 2 □ No	2011	·		
Division		Certification:	4 ☐ Homicide determined	28e. Plece of fn building, e	tc. (Special	ome, farm, str fy)	reet, fact	ory, office			(Street and Ni wn, Stete)	imber or Hu	iral Route Number,
	Hospital or 124 hours effer Funeral Directory filled in t		29a, Certifier 12 Certifying Phy	referent To the best	of muclima	udadaa daat	h	al as sha sta		and due to the			-1-1-1
	Hos Fun Fun	edicai		ystotan: To the best iner: On the bests of end menner st	of examina	ation end/or in	n occurre vestigeti	on, in my o	ne, dete end piece pinion, deeth occu	rred at the time	dete end ple	ce, and due	to the ceuse(s)
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	Me	29b. Signature end title of certifier	end menner s	ateu.		2	9c. Licens	e number		29d. Dete si	aned (Monti	n, Dev. Year)
	FIFE) — ran	FT AL A					8019			3, (29	
			30. Name and address of person who o		,		•		(J 017/0				
		10	Dr. Vasant Datta, 31. Dete filed (Month, Day, Year)						id. Z1/40				
	Sta Registr		TER 2.5 19	98 60	lia Dai	Mason-Ra	indell	-					

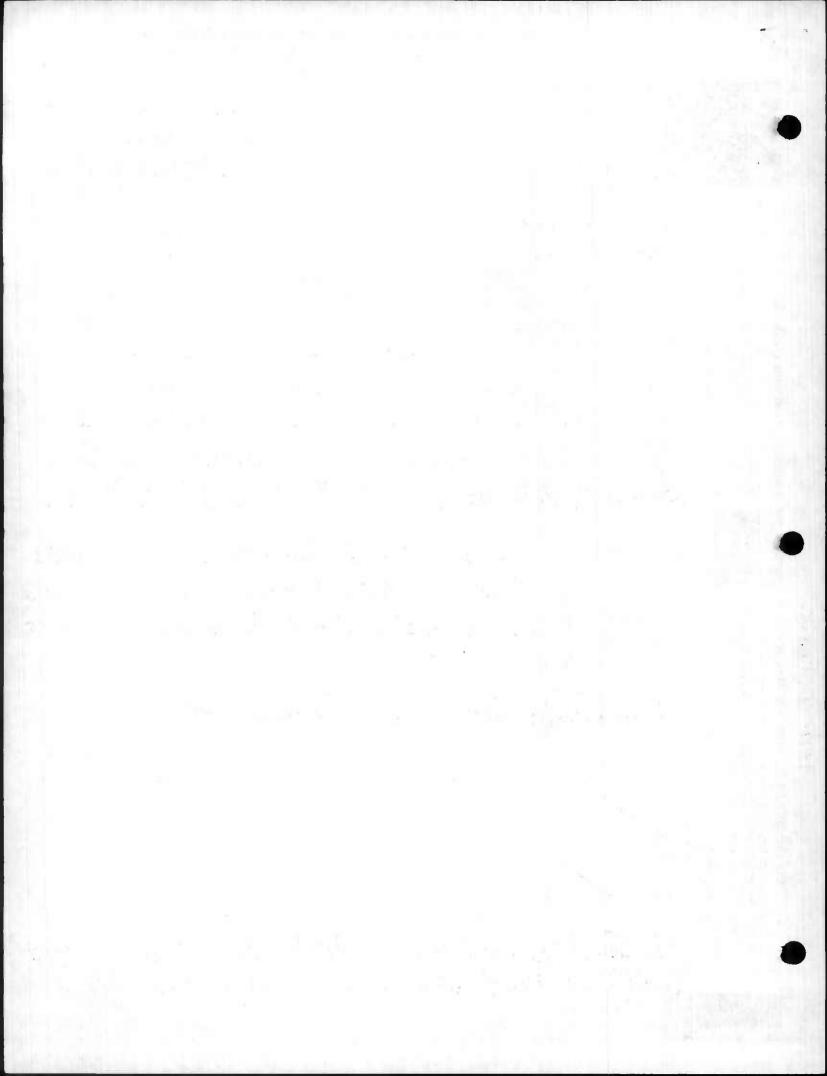


State of Maryland / Department of Health and Mental Hygiene 98

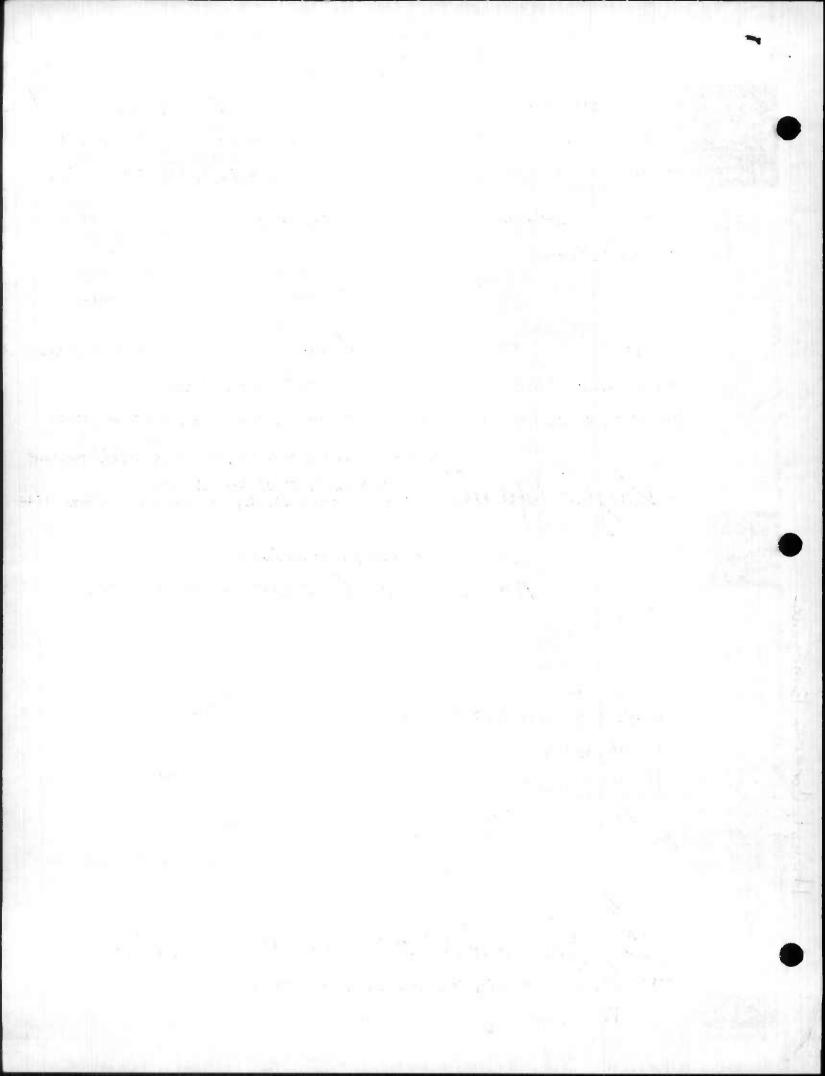
					Certificate	of Death	F	leg. No.	01001
Dhuole		1. Decedent's Nema (First, Middle, La	ist)			_	2. Dete of Dee	th Dey Yeer	3. Time of Deeth
Physic /Medi		Frank	Harmo	on			Februar		0230
Examir		4e. Fecility Neme (If not Institution, give				and the same of the same of	r Location of Deeth	4c. County of Dea	
		Washington Co				Hagers	town	Washir	igton
Funeral Director		220-10-3141	Sex FDM 2□F 7. Age (II	n yrs. last bi	rthday) If Under 1 Months E	Year If Under 24 Hr Days Hours Mir	B. Date of Birth Month, Day	2 ^{Year)} 1912 S	thplece (Stete or Foreign Plat yland
pue M.		Usual Residence of Decedent 10a. Stete 10b. County	10	Oc. City, Tow	n or Location				10d. Inside City Limits
Mary	ō	Maryland Washi		Hager					1 ☐ Yes 2 No
the rotte	Director	10e. Street and Number	16011	nager	10f. Zip Co	ode		log. Citizen of Whet Co	ountry?
3a o		10209 Summers L	ane		217	40		USA	
72 hours after death with the Maryland naturel; or frems 23s or 28s-f show older Evanther must be nutfled at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedant Eve Armed Forces? 1 ☑ Yas 2 ☐ No If Yes, Give Yeer or Detes:	er In U,S.	If Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Pua No Specify:	Specify Yes or No- irto Rican, atc.)	14. Race - Ame Bleck, Whit Specify: B1	te, etc.
n 72 hours "natural".	ted	15. Decadent's E	ducation	16a	Decedent's Usuel C	occupetion	an elein a	16b. Kind of Business	/Industry
<u></u>	Completed	(Specify only highast green Elementary/Secondery (0-12)	College (1-4or 5+)		life. DO NOT use	done during most of wi retired)	orking		
2607	Co		3		machine o	-		Mack Truc	k
2 E T 2	Be	17. Fathar's Nama (First, Middle, Last					ame (First, Middle,		
should be and Mantal marked o	10	Walter	Harmon			Florence		Keys	
d 2 should h and Mar 7 is marke traumatic		Myrtle V. Harmor						r, City or Town, State,	
2 20 20 2		20e. Method of Disposition			0209 Summer of Disposition (Name		Date	n, Maryland	
Pagas nant of int: If It iry or o		1 Burlel 2 Cremetion 3 4 Donetion 5 Other (Special	Removel from State	cam ete	ry, crametory or otha	r place)		Hagerstown	457
pemit. Pag Depertment Important: I any injury o		21. Signature of Funaral Sarvice Licar		R	Gerald N Funeral	Address of Facility N. Minnich	305 N.	Potomac S town, Mary	treet
bath certificata be executed attending physician and for usa as the burial-transit	ledical Examiner	Sequentially list conditions, if any, laading to Immadiata cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest	o. Abdo	ina	consequence of): Consequence of): Consequence of): Consequence of):	: averige	Aneur g	epar's	3 year.
ath for (Physician/M	Post (f. Other plantilleant conditions	d.	- A Ni 4			act Dida		
that the ed by th datech		Part II. Other significent conditions of			er 1	y discus			e to the cause of death* Probably 4 Unknow
Physician: Tha law requires that this cartificate has been signed in director, paga 2 should be dated.	Completed by						24e. Wes a perfor	med?	Were autopsy findings aveilable prior to completion of cause of death?
Tha la ata he paga	Con			/			1□ Y	es 2 No	1 ☐ Yes 2 ☐ No
ysician: The	Be (25. Wes case referred i medical axaminer?	/			26. Plece of De	eeth (Check only or	10)	
5 00	2	1 ☐ Yes 3 € No	Hospitel:	2□ ER/O		-	Home 5 ☐ Resid	ence 6 Othar (Spe	ecify)
ding P. h. After ti	OU:	27. Menner of Deeth 1 ☑ Naturel 5 ☑ Pending	28e. Dete of Injury (Month, Dey Ye			Injury et Work?	28d. Dascribe h	ow Injury occurred	
Attending or death.	cati	2 Accident Investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2 ☐ No			
5455	Certification:	4 ☐ Homicide determined	28e. Pleca of Injury building, etc. (S		erm, street, fectory, o	fice	28f. Location (S City or Town	treet end Number or R n, State)	lural Route Number,
To the Hospital within 24 hours a To the Funeral I complately filled	edicai	29a. Certifier 1 Certifying Ph	ysician: To the best of m	aminetion en	dor investigation, in	he time, dete end pled my opinion, deeth occ	ce, end due to the courred et the time, d	euse(s) end menner a late end placa, and du	s steted. e to the cause(s)
ithin o the xmpla	Mec	29b. Signetura and title of cartifier .	end menner steted	ΛA	29c 1	icense number	9	9d. Dete signed (Moni	th. Dev. Year)
To To		DOTK IN	11/ Donn	1 1/2	,	MD 42	fa	H 1 1	a low
	-	20 Name and a state of the	Varond	LWY	Hun	JU 10.	57	1-62 1	7 1998
		30. Name end address of person who	completed cause of deeth	(item 231)	(Type, Print)	120	Janes	L	217/12
Cha	•	31. Dete filed (Month-Day, Yber)	32. Registrali's	Storiatura	MOC IT	re	inder?	our	11/7/
Sta Begistr		rEB 24 13	198 Julia	Davidson	- Randall		A		

Registrar

Harmon, Frank

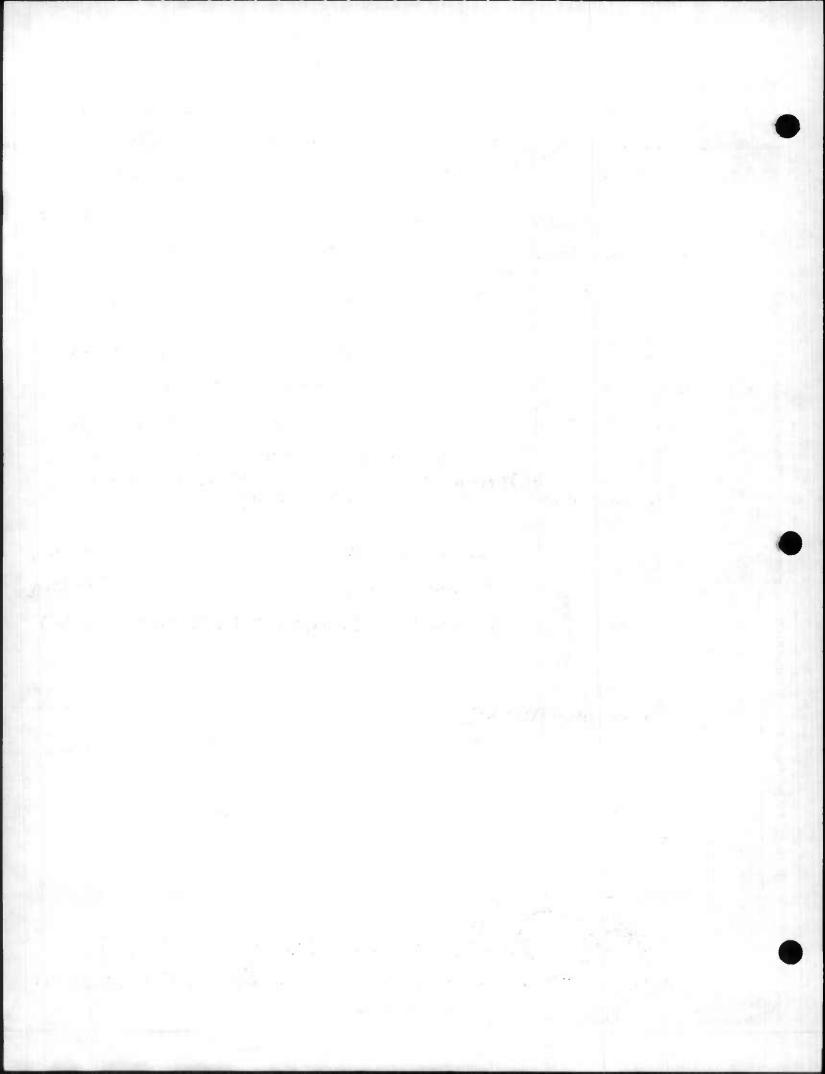


							ificate of			Reg	20	U	1338
	Physici /Medic		Decedant's Nema (First, Middla, CORENA EMOGENE						2. Data of Month		Dey /	Yaar 78	3. Tima of Death 06/4
	Examir		4a. Facility Nama (If not institution, Washington Coun					Ha	own, or Location of D agerstown		4c. County		ngton
	Funeral Director		214-34-9758	5. Sex 7.	Aga (In yrs. las	st birthday) Yrs.	If Under 1 Yaar Months Days	If Undar Hours	Min. 8. Data of (Mont) Sept.	f Birth Day, Ya	1938 W	9. Birthple Count est V	ace (Stata or Foraign ly) Irginia
	ehow	70	Usual Residence of Decedant 10a. Stata 10b. County	-1- '1-	10c. City,	Town or Loc						10	Od. Insida City Limits
	eth with the Marylar 23a or 28a-f ehow	Directo	10e. Street end Number	shington			10f. Zip Coda	Hagers	stown	10g.	. Citizen of W		try?
020	or items	by Funeral Director	810 Georgia Ave 11. Maritel Status 1 Navar Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceda Armed Force	ZWo				igin? (Spacify Yas c n, Puarto Ricen, atc	r No-		USA - Amarica k, Whita, e Wh	an Indian,
Maryland 21215-0020	e filed within 72 hours il Hygiana. other than "naturel", vent, the Madical Ex	Be Completed	15. Decadent's (Specity only highest Elementery/Secondery (0-12)	Education		(Giva k	nt's Usuel Occu ind of work dona O NOT usa retire HOME	during mos		161	b. Kind of Bu	sinass/Inde	
land	a la b	To Be C	17. Father's Nama (First, Middle, La Leonard Howard						ar's Nama (First, Mi Ly Myrtle			a)	
Mary			19a. Informant's Name/Ralationshi Kenneth T. Haup			_			er or Aural Routa Ne, Hagerst				Code) 21740
Baltimore,	permit. Pages 1 end 2 Department of Health e Important: If Item 27 is any injury or other tra ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		te cen	natary, cram	tion (Nama of atory or other pla n Memor		Dete ark Feb. 2		c. Location - G		wn, Steta Maryland
Balti	permit. Depertminimporta		21. Signature of Plinaral Sarvice Li	Sour	(ka)	122	Nama and Addra Douglas	A. F	tery Funer	al F	Home		land 21742
09ere 68760,	Physician Margin Physician Medicai Examiner	Immadiata Causa (Final disaasa or condition rasulting in deeth) Sequantially list conditions, if eny, leading to immadiate causa. Enter Undertying Cause (Diseasa or Injury thet initiated avants rasulting in death) Lest	a. Con-	Dua to (or a	s e consequence de la consequence della conseque	ance of):	fai	Jure Wascu	lar	dis		Onset end Death	
2, P.O. Box	requires that the deeth certif seen signed by the attending should be detached for use e	by Physician/M	Part II. Other significant conditions Diabetes	contributing to death	6		larlying causa gl	van in Part	I. 23b.	Did toba			the cause of death?
erena.	N 2 5	Completed	Emphysen	na					24a.	Was an a performed	autopsy d?	avai	re eutopsy findings illabla prior to npletion of cause leeth?
pt, Con of Vital	uing Physician: The Aftar this certificate funeral director, par	To Be	25. Was case reflarred to medical axaminar? 1 Yes 2 No 27. Marmar of Death Natural 5 Panding			R/Outpatient 8b. Time of Injury	28c. Inju	hae	a ot Daath (Chack oursing Homa 5 28d. Dasc	Rasidanc	a 6 □Otha	r (Specify)]Yas 2□ No
Hau	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral	Certification:	"2	t be 28a. Place of	Injury - At hom etc. (Specify)	a, farm, strae	it, factory, offica	, 100 2	28f. Locat	on (Strae r Town, S	at and Numbe Stata)	er or Rural	Routa Number,
	the Hospi thin 24 hou the Funer mpietaly fill	Medical	(Check only one) Madical Ex	Physician: To the be aminer: On the basis end mannar	of axamination	edge, death on end/or inve	stigetion, in my	opinion, daa	nd placa, and dua to ath occurred at tha t	me, data	and place, a	nd dua to	tha causa(s)
•	T wit	4		LUNAN no completed causa g	pph.), <i>M-</i> 1	29c. Licent	750	91	290.	2/17/	78°	'ay, Tear)
	Sta Registr		1110 Medical C 31. Data tiled (Month, Day, Yaar) FFR 1 8	ampus Road	l, Hagei	rstown	, Maryla	and 2	21742				



State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate o	f Death	F	Reg. No.	0/339	
	Obvete		1. Decedent's Name (First, Middla, Le	st)					2. Date of Dee		3. Time of Deeth	
ı	Physic /Medi		FLORENCE HELEN HA	RDY					02	15 1998		
	Exami		4a. Facility Name (If not institution, giv					4b. City, Town, or	Location of Death	4c. County of D	Deeth	
L		Д,	7436 Mountain Lau					Boonsboro		Washi	0	
	Funeral Director		5. Social Security Number 6. S 216–48–7136 Usual Residence of Decedent	7. Ag	e (In yrs. lest b 75	Yrs.	If Undar 1 Yea Months Day		8. Date of Birth (Month, De) June 10	9. 1922 Wes	Birthplaca (State or Foraign Country) st Virginia	
	/land		10a. Stete 10b. County		10c. City, Tov	wn or Lo	ocation				10d. Inside City Limits	
	Man	to	Maryland Washington Boonsh)		1 ☐ Yes 2 No			
	r 28	Director	10e. Street end Numbar				10f. Zip Code			10g. Citizen of Whet	Country?	
	h wit		7436 Mountain Lau	rel Road			21	713		U.S.A.		
21215-0020	in 72 hours after death with the Maryland "natural", or Items 23e or 28e-f show ted cal Examiner must be notified at	by Funeral	11. Maritel Status 1 □ Navar Married 3 □ Widowad 4 □ Divorced	12. Was Decedani Armed Forces? 1 ☐ Yes, 2 XX If Yes, Give Yeer or Detes:			Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuben, Mexicen, Puerto □ Yes 2XX0 Specify:		pecify Yas or No- o Rican, etc.)	Specific	Unericen Indien, Vhita, atc. White	
2-0	2 ho	ted	15. Decedent's Ed	ducation	166	e. Dece	dent's Usual Occ	upetion		16b. Kind of Busine		
21	C . G	Completed	(Specify only highest green Elementery/Secondery (0-12)	College (1-4or 5	(+)	life.	kind of work don DO NOT use reti	upetion e during most of wor ed)	king			
21	filed within Hygiena. ther than ent, the Mo	Con	12 Years			Ho	memaker]	Personal 1	Residence	
Maryland	0 = 0 5	Be (17. Fethar's Nama (First, Middla, Last)							Maiden Sumeme)		
yla		To	Ray Goodwin					Hazel A	lice Mor	rison		
Jar	and and s m		19a. Informent's Neme/Reletionship (Type, Print)				et end Number or Ru				
	s 1 end f Health Item 27 i		James W. Hardy/Hu	sband			700	n Laurel I	Road, Boo	onsboro,	MD 21713	
ore	8 5 5 0		20a. Method of Disposition **DBurlel 2 Cremation 3 C	Removel from State	20b. Place o	of Dispo e <i>ry, cre</i> r	osition (Neme of metory or other p	ace)	Dete	20c. Location - City	or Town, Stete	
E	Pages ment of I ant: If Ite ury or of		4 ☐ Donetion 5 ☐ Other (Specific	v)	Cedar	Law	m Mem.	Park 02/19	9/98 1	Hagerstow	n, Maryland	
Baltimore,	permit. Pages Depertment of Important: If it any Injury or once.		21. Signetura of Funeral Service Licer P. Steven Danf	elt, Jr.	spects.	•	2. Neme end Add	RAL HOME I		National		
	_		23a. Part1. Enter the diseasa, or com shock, or heart failure. List only		the deeth. Do	1				,	Approximete	
Ç.	Physician		Shock, of field failure. List only	one cause on each in	16.						Interval Between Onset and Death	
	/Medical		Immediate Ceuse (Finel diseese or condition	C	(=DTI	((m (A				1-77 Acc	
	Examiner		resulting in death)	θ	Due to (or as e						1 C. Daler?	
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	ntificata be axecuted ng physician and e as the burial-transit	Examiner	Sequentially list conditions,	0.	Due to (or es e						1	
Ö,	e axe ian a urial-		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	7,1	1 AL	(6	1 CA	uc (wan a	+ OF	Curre	6/57	
68760,	hysic the bi	Medical	that initiated events resulting in death) Lest	c	Due lo (or es e	conseq			, 01	000.0	0(0)	
	a a	Mec	Treating in Gentl Least									
Box		an		d							1	
0	0 0 0	Physician/	Pert il. Other significant conditions of	ontributing to death bu	it not resulting	In the u	nderlylng cause g	iven in Pert I.	23b. Dld to	obecco uee contrib	ute to the ceuse of deeth?	
9.	thet the ed by th detache	Phy	BONE ME	DIDAPH	P				1 □ Y	'es 2□ No 3□	Probably 4 Unknown	
_	5 6 9	by	- 1 DONC THE	-1)11150	7							
Records,	aw requir	Completed							24e. Wes e perfor		lb. Were eutopsy findings evaileble prior to completion of ceusa of deeth?	
r	8 4 6	On							1 □ Y	es 20No	1 ☐ Yes 2 ☐ No	
of Vital	ysician: Thi is cartificate director, pag	To Be C	25. Was case referred to medical	26. Plece of Dae	teth (Check only one)							
>	00		exeminer? Hospitel: Other:							ome 5 Difesidence 6 □Other (Specify)		
	g Ph ter th		27. Menner of Deeth 1 □Naturel 5 □ Pending	28e. Dete of Injur (Month, Day	y 28b.	Time of	28c. Inj	ury el	28d. Describe h	ow injury occurred		
0	Attanding or death. octor: Afte by the fune	atic	1 ■ Naturel 5 □ Pending 2 □ Accident investigation		7 047)	irijary		Yes 2 No				
Division	al or Attanding s efter death. I Director: After ad in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ HomicIde determined	28e. Plece of Injubuilding, etc		arm, str	eet, fectory, office	•	28f. Location (Si City or Town		r Rurel Route Number,	
	To the Hospital or Attanding F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifler (Check only one) 1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated.									
	To th withir To th	M	296. Signature of a tale of agriffier	FAMILY P	H4 31C1A	~	29c. Licer	nse number	2	9d. Date signed (M	onth, Dey, Year)	
			D ///	Destan	t-10 (-)	hor	1441	DAG		710	102	
		1	30. Name end eddress of person who	combined cause of de	eath (Item 23e)	(Type	Print) "	1/00	1	11711	(10	
			CT-OLIVA) EAR	ETZNEZ	LIL	(.)he'	747 1	IN THETEL	Huo	Hnean	Moun lest	
	Sta	te	31. Dele filed (Month, Dey, Yeer)	32. Regist	r's Signature	-		7	1000	1 100	- i decor	
	Registr			998 D	his David	SON-1	andelle	l .				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month HORST 046G Myra Leona February 12 1998 C. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown Washington County Hospital Hours Min. 8. Date of Birth (Month, Day, Year) March 2, 1936 If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🖾 F 186-28-7484 Yrs. 61 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maugansville 1 ☐ Yes 2 No Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21767 13739 Village Mill Drive 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2000 f Yes, Give Year or Dates: 1 Never Married 2 X Married white 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) cashier market 0 - 817. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Rebecca Verdier Floyd Rock 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13739 Village Mill Drive, Maugansville, Maryland Mr. Charles Horst/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State Zion Church Cemetery 1998 4 ☐ Donation 5 ☐ Other (Specify) Quincy, Pennsylvania 21. Signature of Funeral Service Licensee __22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Deeth minal Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting In death) Last Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3☐ Probably 4☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) of Death 28b. Time of 28d. Describe how Injury occurred

The law requires that the death certificate be executed the buriel-tran for use sate hes been signed by the a page 2 should be deteched to

Records, P.O.

Physician:

Attending

ò Hospital within 24 hours e To the Funeral C

Examiner Physician/Medical Be Completed by certificate Medical Certification: To this funeral After ofter death Director:

Physician

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7 is marked other than "naturel", or items 23a or 26a-f show treumstic event, in Mooical Examiner must be northed at

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Hygiene.

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Depertment of Important: If any injury or injury or

Physician

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21215-0020

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Saltimore.

/Medical

1 Yes

atural 2 Accident 3 Suicide 4 - Homicide

5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 Tyes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29b. Signature and title of certifier

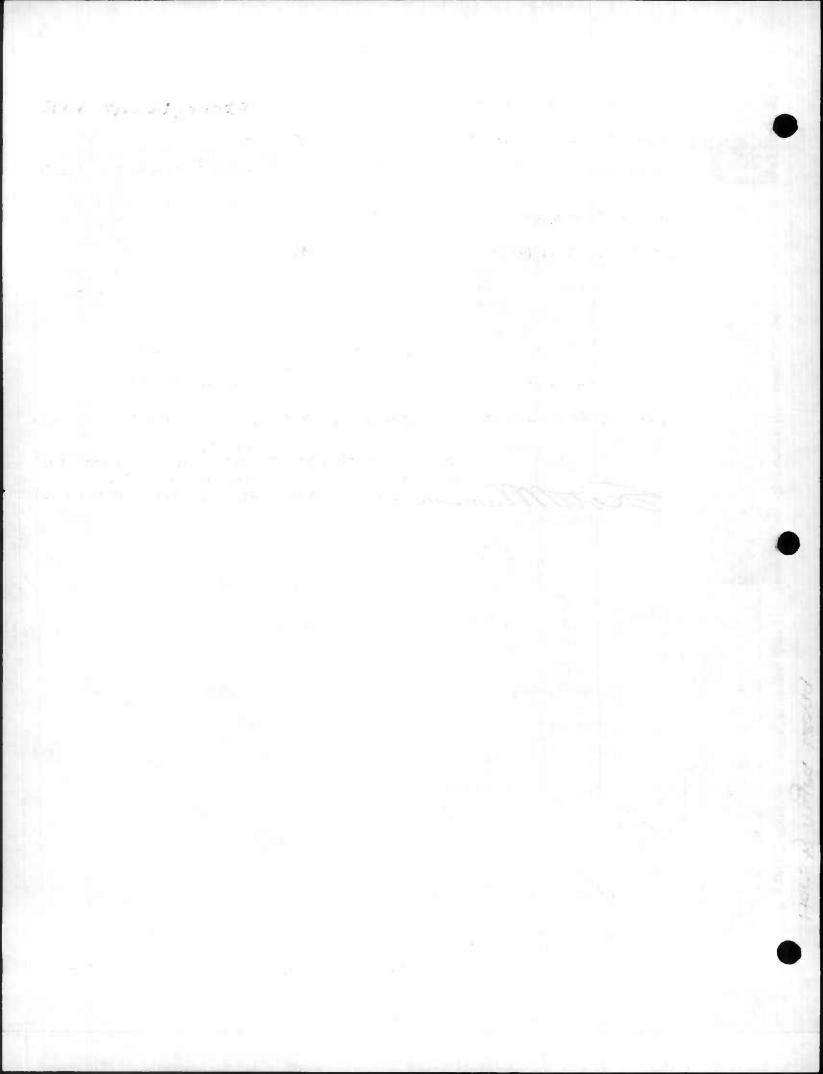
29c. License number

is) of deeth (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

filled in by



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Funerai Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

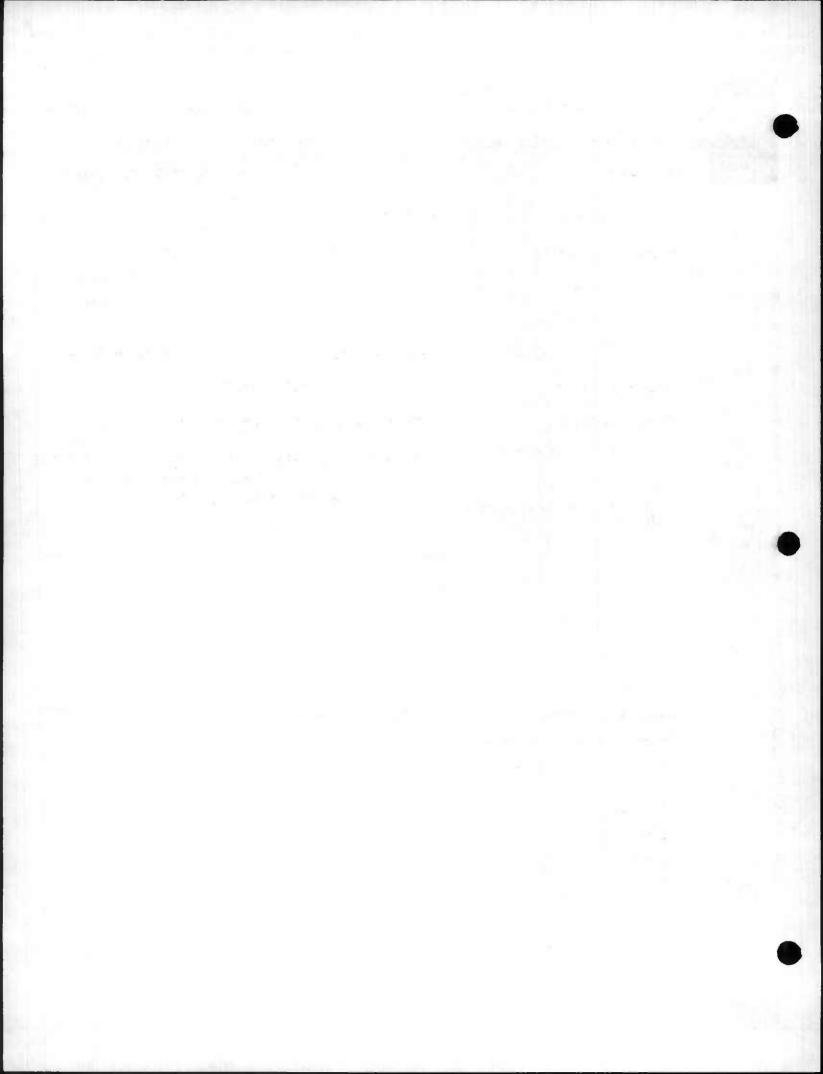
Physician /Medicai Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

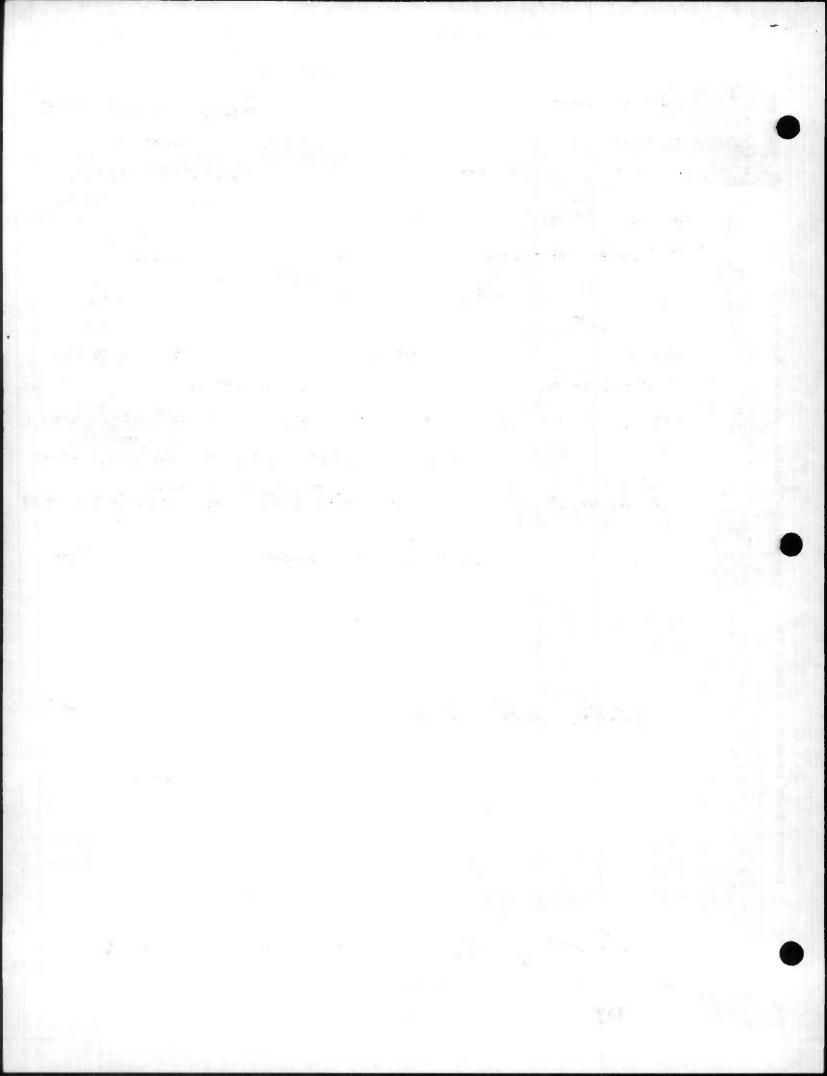
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, paga 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



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edical	Ca tha re:	equentially list con any, leading to imra ause. Enter Under ause (Disease or li at initiated evants ssulting in daath) Li		c	Due to (c	or as a consequ	uence ot):						
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Physician/Medical	Ca tha re:	at initiated evants	ast	b	Due to (o	or as a consequence or as a consequence of the cons	uence ot):	ven in Part I.			ontribute to the cause of d		
by Physician/Medical	Pa	at initiated evants esulting in daath) La	ast		Due to (o	or as a consequence or as a consequence of the cons	uence ot):	ven in Part I.	1 ☐ 24a. Was				
Completed by Physician/Medical	Pa	art initiated evants soutting in death) Li	cant conditions		Due to (o	or as a consequence or as a consequence of the cons	uence ot):		1 □ 24a. Was perfo	Yes 2□ No an autopsy ormed? Yas 2☑No	3 Probably 4 Unit		
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Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requiras that the death certificate be axeculed Division of Vital Records, P.O. Box 68760, Mary Elizabeth KOONS

				Cert	tificate	of i	Death			Reg. No.	3 0	7343	
cian	1. Decedent's Neme (First, Middle,	,							2. Dete of De Month	Dey	Yeer	3. Time of Death	
lical	Mary Elizabet 4e. Facility Name (If not institution,)			- 4	\$b. City. To	wn. or l	Februa		1998 y of Death	12:10 PM	
iner	Ravenwood Luth						Hage				hingt	on	
il			ge (In yrs. lest b	st birthday) If Under 1 Yaar Months Deys			ar If Undar 24 Hrs.			th Yeer) 31, 1905	9. Birthp	piece (State or Foreig	
r.	212-74-8473 Usual Rasidence of Decedent	ILM ZDF	92	Yrs.	Months	70,5	Tiodis	IVIIII.	March	31,1905	Mar	ÿíand	
	10e. Stete 10b. County		10c. City, Tov	vn or Loca	etion						1	Od. Insida City Limits	
ctor	Maryland Was	nington		Н	agers	tow	/n					1 ☐ Yas 2 💢 No	
Director	10e. Streat and Number				10f. Zip Co	ode			Ш	_	on of Whet Country?		
ra	217 Longview Dr					174			USA				
Funeral	11. Maritai Status 1 □ Navar Married 2 □ Married	12. Was Dacedent Armed Forces?		13. W	es Dacaden Yes, specify	Cuba	ispenic Ori in, Mexicar	gin? (Sp n, Puarto	pecify Yas or No Rican, etc.)		ce - Americ ck, White,		
by	3√ Widowed 4 Divorced	If Yes, Give Year or Detes:	140	1[☐Yes 2☐	No	Specify:		Specify:			ite	
Completed	15. Decedent's (Specify only highest t	Education	166	. Decede	nt's Usuel C	ccup	etion	t of work	16b. Kind of Busin			inass/Industry	
mple	Elementery/Secondery (0-12)	College (1-4or !	5+)	life. DO	House	etirea	1)	. Or WOIN	ung	н	ome		
	8 17. Fethar's Name (First, Middle, La	st)			110036	SW I		er's Nem	e (First Middle	, Melden Sumei			
To Be		Bierman			Mary Elizabeth (UNK)								
	19a. Informant's Name/Relationship		19	b. Meiling	Address (S	treet				er, City or Town		Code)	
	George S. Koons	, Jr./Son					Ave.	На	gerstow	n, MD	2174	0	
	20e. Method of Disposition 1 🖾 Buriel 2 □ Cremetion 3	☐Removel from Stale		ry, creme	tory or othe	r plac	·	i	Date	20c. Location			
	4 Donetion 5 Other (Special Service Lic	cify)	Green	-		_			-20-98	Willia	nspor	+, MD	
	21. Signatural Salvice Co	$m \wedge 1$	/		Name and A Dorne								
	23a. Pert1. Enter the disaasa, or co shock, or heart failure. List on	mplications that caused	the death. Do								sport	, MD 21795 Approximete	
	shock, or heart failure. List on	ly one ceuse on aech lii	ne.			1			, , , , , ,	,		intervel Between Onset end Deeth	
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L.	resulting in deeth)	0.	Due to (or es a									7	
Examine	b. Spectrum.												
Exa	Sequentially list conditions, if any, laeding to immadiate cause. Enter Underlying	tially list conditions, eding to immadiate									1		
cal	Ceuse (Diseese or Injury thet Initieted avents	c	Dua to (or as e	conseque	nce of):								
Med	resulting In death) Last			·									
ian		d.											
Physician/Med	Pert II. Other significant conditions		0.	n the und	erlying caus	e give	on In Pert I.		23b. Did			the cause of death	
by PI	old ory	rounded	July	bet	n	M	2		1	Yes 25tho	3 ☐ Prot	bebly 4 Unknow	
	Co	rondrel	- 6	Les	UT	-	7ai	h	24e. Wes	en eutopsy	24b. We	ere eutopsy findings eilable prior to	
Completed		0							7			mpletion of causa deeth?	
် ပ	·								10	Yes 20No	10	Yes 2 No	
o Be	25. Wes case referred to medical axaminer?	Hospital:				Othe			h (Check only o				
-	1 Yas 2 No	1 ☐ Inpatia 28e. Dete of Injur		tpatient Time of			45 190	7		dence 8 Oth		/)	
atlor	1 Netural 5 Pending 2 Accident Invastigati	(Month, Pay	Year)	niury X	М	Injury Work	7 /as/\2 D	,	\//	/	160		
Certification:	2 Accident 3 Suicida 4 Homicide 4 Homicide 6 Could not be determined 28e. Piace of Injury - At home, ferm, street, factory, office building, etc. (Specify) City or Town, State)								per or Rura	l Route Number,			
	29e. Certifier Certifying P	hyelclan: To the best of	of my knowledge	, deeth o	ccurred et th	ne tim	e, dete en	d piece,	end due to the	ceuse(s) end m	enner as st	eted.	
edicai	(Check only 2 Medical Exa	miner: On the besis of end menner sta	exeminetion en	d/or inves	stigetion, In r	пу ор	olnion, deet	h occurr	ed at the time,	dete end piaca,	and due to	the ceuse(s)	
Σ	29b. Signature and title of certifier				00 11		number			29d. Date signe	1 60 4 44 4		

Disease Time on Drink in Disease to titule July

State

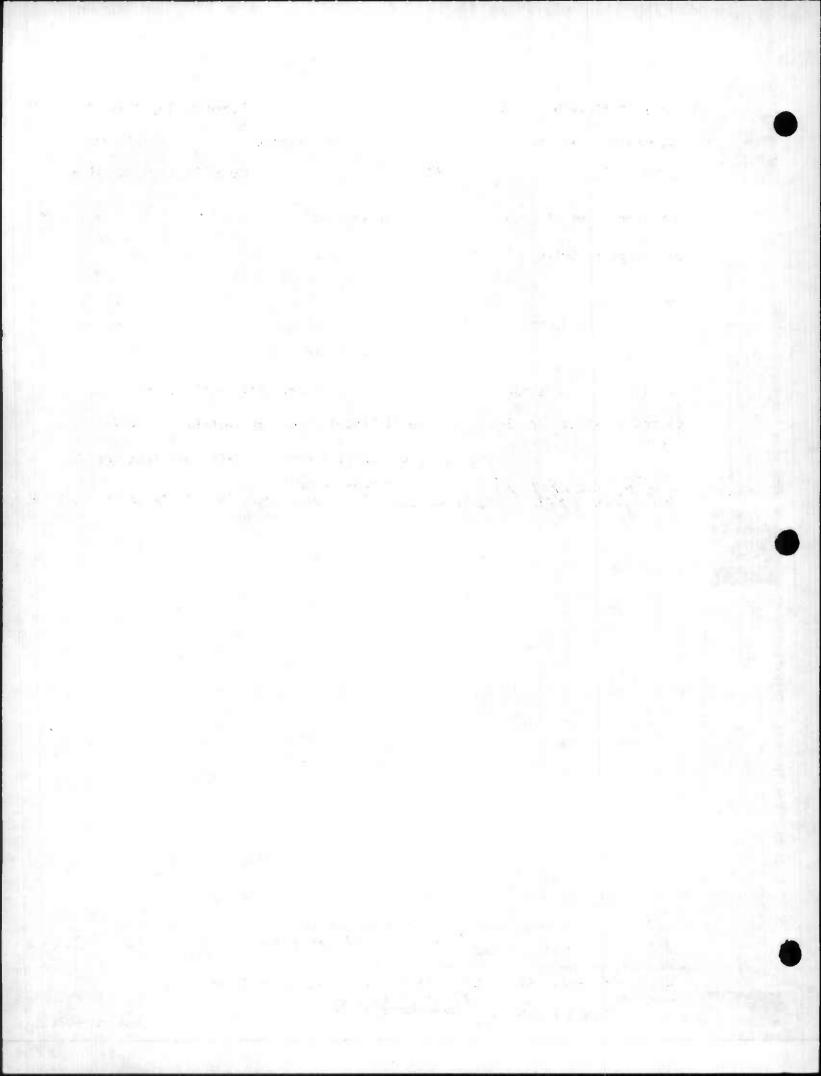
Registrar

Dr. Gloria Pura 31. Date filed (Month, Dey, Year) FEB 17

Neme and eddress of person who completed causa of deeth (Item 23e) (Type, Print)

MD 366 Mill St. Hagerstown, Md. 21740

1998 Sune Davidson Andell



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death February 14, 1998 **Physician** Marie Shirley KNODE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 223 Ross Street Hagerstown Washington If Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) Sept. 19,1935 5. Social Security Number if Under 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Months Days 1 ☐ M 2 🖾 F 217-30-6005 62 Yrs Maryland Director Usual Residence of Dacedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show treumatic event, the Medical Examiner must be nothing at Washington Hagerstown Director YYas 2 No 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 23a or 223 Ross Street 21740 U.S.A. death v Funeral Heme 11. Marital Status 12. Was Decedant Evar in U,S Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) Race - Amarican indian, Black, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours effer Department of Health and Mental Hygiana. Interportent: If Item 27 is marked other than "natural", or its any Injury or other treumatic event, tre Mexical Examina any Injury or other treumatic event, tre Mexical Examina any anos. 1 Naver Married 2 Married 1 ☐ Yas 2 ☒ No altimore, Maryland 21215-0020 white 1 Yas 2 No Specify: þ 3 ☑ Widowad 4 ☐ Divorcad Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 15. Dacadanf's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 0 - 12waitress restaurant 17. Fefhar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middia, Maidan Surname) Be Alston Walls Bonita Colbert 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 13718 Pennsylvania Avenue, Hagerstown, Maryland 21740 Mrs. Donna Potter/daughter 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from Stata Feb. Cedar Lawn Memorial Home 4 ☐ Donation 5 ☐ Other (Specify) 1998 Hagerstown, Maryland 21. Signators of Funeral Service Licenses 2. Nama and Addrass of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarvel Batween Onsat and Deeth **Physician** /Medicai immediate Causa (Final Obstructive Pulmary Mean disaase or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use es the buriel-transit Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury Due to (or as a consequence of) P.O. Box 68760, that initiated events rasulting in death) Last Due to (or as a consaguance of) signed by the aid to be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? abela 1 Yee 2 No 3 Probably 4 Unknown Melli Ci, Records, þ Completed 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No of Vital or Attending Physician: Be 25: Was casa rafarred to medical axaminar? 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatiant 3 DOA this 27. Mannar of Death 1 Natural 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred After t Division 5 Panding investigation To the Hospital or Attending within 24 hours efter deeth.

To the Funeral Director: Afte completely filled in by the fun 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28a. Place of injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 4 Homleide Cartifying Physician: To the best of my knowledge, death occurred at the fime, data and place, and due to the causa(s) and manner as stated.

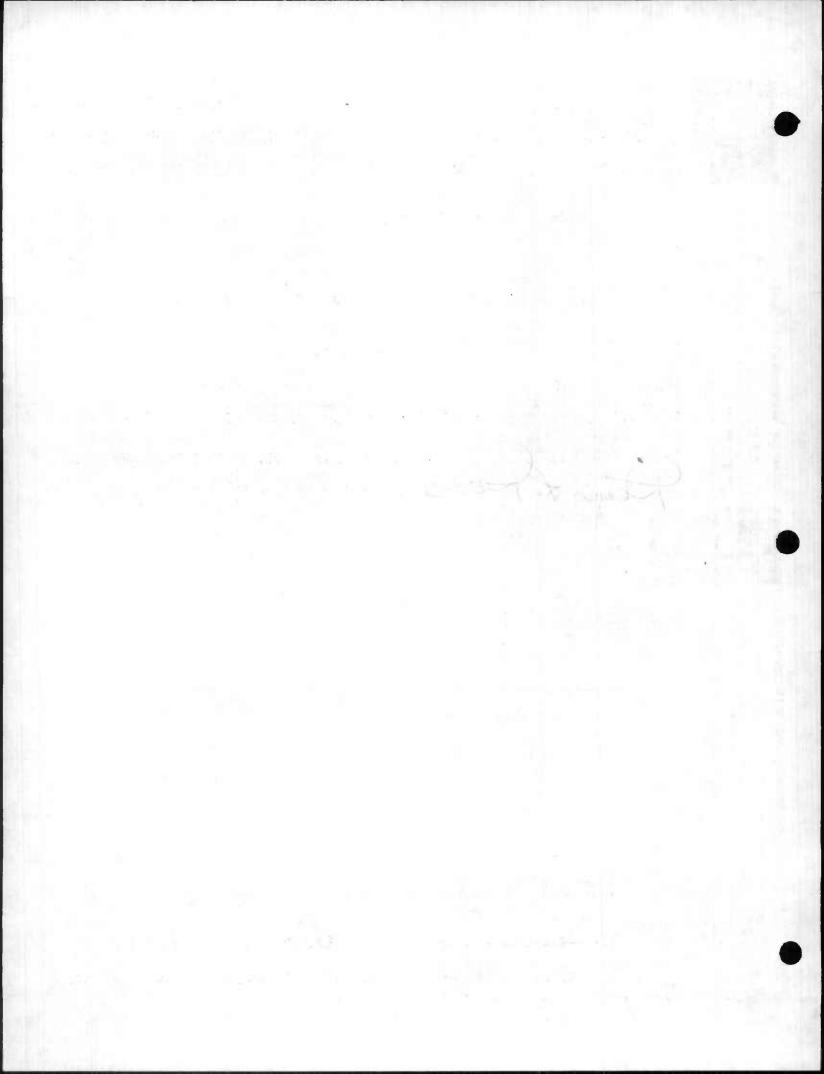
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the fime, data and place, and due to the causa(s) and manner stated. 29e. Certifian Medicai (Check only one) 29b. Signature and fitla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 2-16-98 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) ABOUL WATERD MO 12821- OAK HILL AVE. HAGERSTOWN MO 31. Data filad (Month, Day, Yaar) State FEB 1 Registrar

Memorial Committee of the Committee of t

State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Name (First, Mic	ldle, Last)		Jei	uncate (of Death	2. Date of De	Reg. No.	0	3. Time of Death	
Physicia		Susan Ma	e Leggett					Month Feb.	22°, 1	988	4:05 P.N	
/Medic Examin		4a. Facility Name (If not institut Vindobon	ion, give street and nur a Nursing f				4b. City, Town, or Braddock	ocation of Death	4c. County			
oFuneral Director		5. Social Security Number 144-30-1022	6. Sex 1 □ M 2 □ XF	7. Age (In yrs. last. 82	(In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jun. 18, 1915 New Jours Country Count							
* _		Usuai Residenca of Decadent 10a. State 10b. Coun	tv	10c. City, To	nwn or Lo	cation						
n or 28a-f show be notified at	0	N.J. Ber			kenso						lod. Inside City Lim 1√2 Yes 2□	
288	rect	10e. Street end Number	9011	Hac	icensi	10f. Zip Cod	le .		10g. Citizen of	What Cour	^	
a 23a or must be	Funeral Director	65 First St.	40 Wes Book	dest Francis III O	10.1		07601		u.s	.A.		
o','a	by	11. Marital Status 1 Never Married 2 Marital 3 Wildowed 4 Divorce	Armed Fo 1 ☐ Yes	2 ☑No e		Vas Decedent Yes, specify C	of Hispanic Origin? (S cuban, Mexican, Puert No Specify:	pecify Yes or No p Rican, etc.)		14. Race - American indian, Black, White, etc. Specify: White		
netu	etec	15. Decade (Specify only high	ent's Education lest grade completed)	16	Sa. Dacad	ant's Usuai Oc	cupation ne during most of wor tired)	kina	16b. Kind of B	usiness/in	dustry	
Hygiene. ther then " int, the Me	To Be Completed	Elamantary/Secondary (0-12		-4or 5+)	life. D				11 00			
el Hygiene. I other than	ပိ	17. Father's Name (First, Middle				Homema	18. Mothar's Nam	o /First Middle	Hor			
ked of	Be c	Joseph M. Leg						e Finla		ne)		
pue mae	ř	19a. informant's Name/Relation	nship (Type, Print)	athat 1	9b. Mailin 7 3 0 0	g Address (Str	eet and Number or Ru	ral Route Numbe	er, City or Town,	Stata, Zip	Code)	
m 27 her t		Frederick N. Leggett (Brother) 7399 Old Line Ct. Middletown, Md. 21769 20a. Method of Disposition 20b. Place of Disposition (Name of camalary, crematory or other place) 20c. Location - City										
it of it		20a. Method of Disposition 1 Burial 2 D'Cremation	3 Removal from					Dete	20c. Location			
tant:		Donation 5 Other	Specify)	Smit			atory Feb.	23,199	8 Smith	sburg	,Md.	
Department of Health Important: if item 27 any injury or other tr once.		2 Signature of Funeral Berrio	e Licenson	turs			dress of Fecility NETAL HOME		Bradburi burg, Md			
		23a. Part 1. Enter the disease, shock, or heart tailura. Li	or complications that ca	aused the death. D	o not ente	or the mode of	dylng, such es cardiac			. 217	Approximate intervel Between	
nysician			or only one odebo of or	aori mia.						-	Onset and Deeth	
Medicai xaminer		Immediate Cause (Final disease or condition	CAR	DIOMYC	PAT	144				1	Years	
		resulting in daath)	a	Due to (or as	a consequ	uence of):					Years	
₩.	ine		TRIC	USPID 1	LEGI	ROITH	3 NOTE	BABLE		į	years	
and I-tran	Examiner	Sequentially list conditions,		Due to (or as	a consequ	uence of):						
ician	a E	Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Diseasa or injury	C									
es been signed by the ettending physician and 2 should be deteched for use as the buriel-transit	Medicai	thet initieted evants resulting in death) Last	L	Due to (or as a	consequ	ienca of):						
ed by the ettendir	Physician/	Part ii. Other eignificant condit		ath but not resulting	In the un	darlying cause	given in Part i.	23b. Did tobacco use contribute to the ca			the cause of dea	
and by	by Ph	CHRONIC RE	ente insc	FFICION	EY			101	ree 212No	3 □ Prol	oably 4 ☐ Unkn	
s been signed be should be dete	Completed							24a. Was	an autopsy med?	CO	ara autopsy finding eliebie prior to impletion of cause	
4 0	Ē										death?	
certificate rector, pag		25. Was case referred to medic	al .					1 U Y		1 [JYes 2□ No	
is certific director,	00	examiner?	Hospitai:			оП ВО 1	26. Placa of Dea Othar:					
r this certific	1: 10	27. Manner of Death		patient 2 ER/C	. Time of	3LI DUA	4 Hoursing He	ome 5 Resid			()	
octor: After by the fune	0	1 Matural 5 ☐ Pend 2 ☐ Accident inves	ng (Month	, Day Year)	injury	V	Vork? ☐ Yes 2☐ No					
ofter dea Director I in by the	Certification:	3 Suicide 6 Couid	not be 28e. Place	of injury - At home, g, etc. (Specify)	farm, stre			28f. Location (S City or Tow	itreet and Numb n, State)	er or Rure	l Route Number,	
	edical C	29a. Cartifier 1 Cartifyi	ng Phyaicfan: To the b Examinar: On the ba	sis of axamination a	ge, death and/or inva	occurred at the	tima, date and place, y opinion, daath occur	and due to tha d	eause(s) and ma	nner as st	ated. the cause(s)	
thin the mple	-	29b. Signature end title of certil	and menn	er stated.								
¥ + 8		244	enle	ans			D294	88	29d. Date signe 2 27	98	uay, 1081)	
		30. Nama and address of person	who completed cause	of death (item 23a)	(Type, P	rint)						
		JAMES L.	6/	or mo	Po	BOX	7, Mis	DLETON	m, me	21	769	

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

_							ertificate of			eg. No.	0	1341	5	
П	Physic	ian	Decedent's Name (First, Mid		77 - 1				2. Date of Dea Month	2. Date of Death Month February 20 1998			Death	
J.	/Medi			largaret	Esthe	er	Lewis					2:00	AM	
	Exami	ner	4e. Facility Name (If not institut Frederick Mem					4b. Clty, Town, or L Frederic		4c. County	of Deeth reder:	ick		
	Funeral Director		5. Social Security Number 217–28–6359	6. Sex 1□ M 2√7 F	7. Age (In yrs. 78	. lest birthd Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Dey Dec. 29,	Birth 9. Birthplace (State or Foreign Country) , 1919 Maryland			vr Foreign	
	and *		Usual Residence of Decedent 10a. State 10b. Coun	ıtv	10c. Ci	ity, Town o	Location				10	Od. Inside Ci	itu limita	
	/anyl	5	2.25	•							10	ty⊡ Yes		
	1 the	rec	Maryland Frede 10e. Street and Number	rick	FI	ederi	10f. Zip Code		10g. Citizen of What			try?		
	h with	D I	7 North Wisne	r Street			21701			USA				
21215-0020	n 72 hours after death with the Maryland "naturel", or items 23a or 28a-f show solded Examiner must be notified at	by Funeral Director	11. Maritel Status 1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divorce	Armed Fo	2 No	J,S. 1	3. Wes Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No		pecify Yes or No- p Rican, etc.)	Blac	14. Race - American Indian, Black, White, etc. Specify: White			
2-0	72 ho	eted	15. Deced	ent's Education nest grede completed)		16a. De	cedent's Usual Occu ive kind of work done a. DO NOT use retire	pation	kina	16b. Kind of Bu	usiness/Ind	ustry		
121	C 4	Completed	Elementery/Secondary (0-12		-4or 5+)			ed)	, , , ,					
2	il Hygiana. other than	S	12 17. Father's Name (First, Middl	e / ectl		Hom	emaker	18. Mother's Nam	o /First Adiddle	Own Ho				
Maryland	o dai	Be C	Chester C. Kuh						H. Drape		10)			
37	d 2 should th and Mar 7 Is marke treumatic	To	19a. Informant's Name/Relatio			19b. M	ailing Address (Stree	1	*		State Zin	Code)		
	Ta Pa		Lana Shelton,		er		orth Wisne						01	
Baltimore,	f Haalth Item 27 other tr		20e. Method of Disposition		20b.	Place of Di	sposition (Neme of cremetory or other ple	acal	Dete	20c. Location -	City or Tov	wn, Stete		
E	Pagas nant of I unt: If Ite		ty Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal from : (Specify)	State			-	-23-98 N	lversvi	11e.	Marv1	and	
att	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specify) Grossnickle Ch of Breth 2-23-98 Myersville, Maryla 21. Signature of Foreital Service Licansee 22. Name and Address of Facility 504 Main Street											
m	88 2 2 8		1 Xmis	P. Duki	des		Ricketts F	uneral Ho		rsville				
	_		23a. Part1. Enter the dilease, shock, or heart full re. Li	or consolications that cast only one cause on e	aused the dee	th. Do not	enter the mode of dyi	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Bet	6	
	Physician											Onset and D	Death	
Ĺ	/Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)	. (0	NGEST	100	HEMRT	FALLY.	RE			2 DAY	'5	
		<u>-</u>	Tooling it doutly	2	Due to (or as a con	HEART sequenca of): ARTERY	^				YEAR	0.4	
	ned I Insit	Examiner		b. Co.				y bist	ASE		1	16/11	<5	
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68760,	tificata be axecuted ig physician and as tha burial-transit	Ca	Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of):											
	The Color	Med	resulting in deeth) Last		(.		,							
Box	th ca tendii	any		d										
	that the death cered by the attendir detached for use	Physician/N	Part II. Other significant condi-	tions contributing to de	ath but not res	sulting in the	e underlying cause gi	ven in Part I.	23b. Did to	bacco use co	ntributa to	the cause o	of death?	
P. 0	d by	£	DIABETES	MELLITO	15				1□Y	08 2 No	3 Prob	ably 4 🗆	Unknowr	
of Vital Records,	sign d be	d by							046 14/00 6	n autonou	24h Wa	re autopsy fi	lindings	
Ö	been should	Completed	RECURRENT	CONGES	TIVE F	TEAR	T FALLUI	20	24a. Wes a perform	n autopsy ned?	ave	ilable prior to apletion of co	0	
Re	The law eate has b	d m								- 674		leath? NA		
<u>r</u>	sician: Tha law cartificata has b firector, paga 2 s		25. Wes case referred to medic	nal T				00 50 (5)	1 Y		1	Yes 2	No	
>	Physician: this cartific ral director,	To Be	examiner? 1 Yes 2 P-No	Hospital	npatient 2	ER/Outpe	tient 3 DOA Otl	her:	th (Check only on		er /Snecity	-)		
0	g Phys ar this naral d		27. Manner of Deeth	28a. Date o		28b. Time	of 28c. Inju		28d. Describe ho			,		
Ö	Attending I ir daath. ector: Affar by the funar	atio	E C / tooldont	tigation	M7	Injur	,	Yes 2□No						
Division	s after death I Director: od in by the	Certification:	3 Suicide 6 Coulded	mined 288. Placa	of Injury - At h ng, etc. <i>(Speci</i>	ome, farm,	street, factory, office		28f. Location (Si City or Town		er or Rural	Route Num	ber,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical (29a. Certifier (Check only one) 1 Certify 2 Medica	ring Physician: To the at Examiner: On the ba end mann	sis of examina	owledge, de ation and/or	ath occurred et the ti	me, date and placa, opinion, deeth occur	and due to the cared at the time, d	ause(s) and ma ate and place,	nner as ste	eted. the cause(s)	
	within To the	Me	29b. Signature end title of cartif	n	•		29c. Licens		2	9d. Date signe	d (Month, D	ley, Year)		
	,- ,- 0			Im	yr.	N	no D	18063		2/20	198			
,			30. Name and address of person ABDUL M	n who completed cause	of death (Iter	m 23a) (Typ	pe, Print) OLL HOUSE	AUE FI	REDERIE	•		70/		
	Sta	to	31. Date filed (Month, Day, Yea		egistra 'e Sign:			1100,1				•		
	Registr		FEB	3 1998	Julia	andr	Barlos							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 02 **Physician** 1998 10:00 P.M. EVELYN IRENE LESCALLEET 19 /Medical 4e. Fecility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4437 Locust Grove Road Rohrersville Washington | Months | Days | Hours | Min. | State of Birth (Month, Dey, Year) | July 14, 1926 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M & F Yrs. 71 Director 212-24-3379 Maryland Usual Rasidanca of Decedant 10a Stata 10b County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Wed cal Examiner man be notified at 1 Tyes 2 No Director Maryland Washington Boonsboro 10a. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 8 High Street 21713 U.S.A. Funeral 12. Was Decadant Evar in U,S. Armad Forças? 1 ☐ Yas 20XNo If Yas, Giva 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Black, White, atc. 11. Marital Status 72 hours after 1 ☐ Navar Marriad 2 ☐ Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: by Specify: White 3 Widowed 4 □ Divorcad Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Medagone. (Spacify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Personal Residence 17. Fathar's Nama (First Middle Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) Lester William Smith Ella Mae Yost 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Straet and Number or Rurel Route Number, City or Town, Stata, Zip Code) Marvin R. Lescalleet, Son 4437 Locust Grove Road, Rohrersville, MD 21779 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 N Burial 2 □ Crametion 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Boonsboro Cemetery 02/23/1998 Boonsboro, Maryland 21. Signatura of Funaral Sarvica Licensaa 22. Name end Addrass of Facility P. Steven Danfelt, Jr. I. OR 7606 Old National Pike BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximeta Intervel Between Onsat and Death **Physician** indespread hetertuars

Due to (or es a consequenca of):

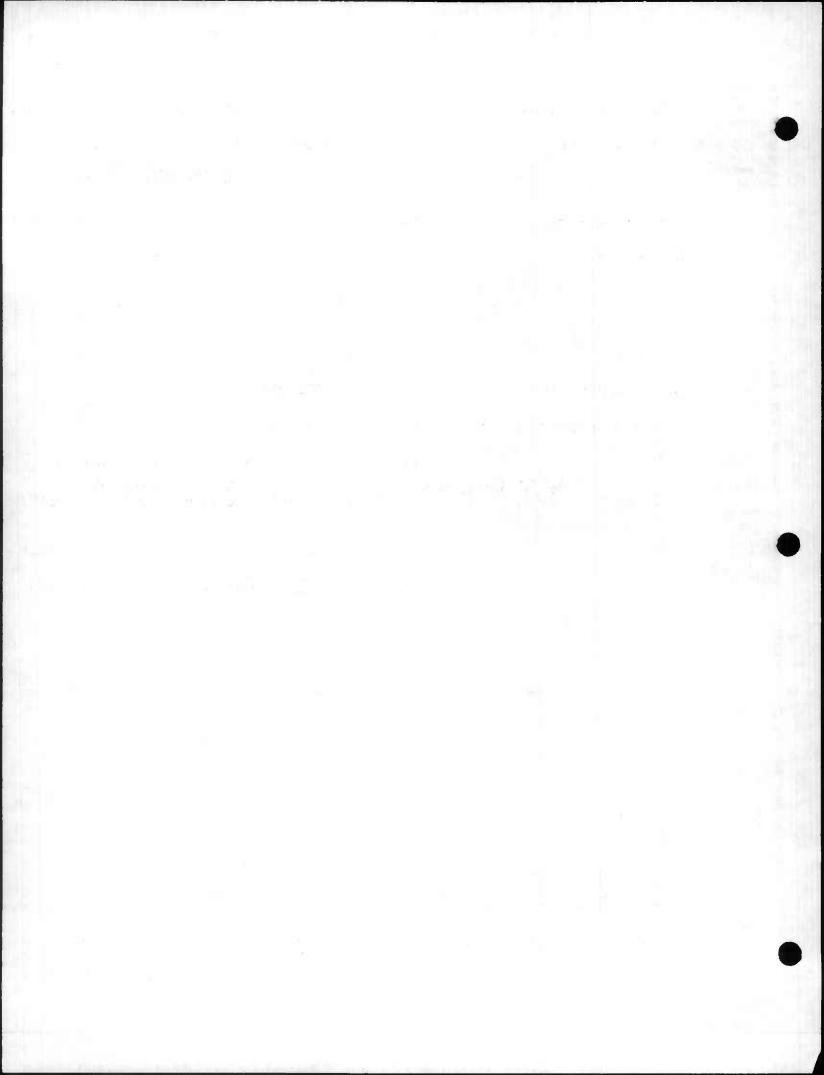
When the Creat /Medical Immediate Causa (Final mucha disaasa or condition rasulting in death) Examiner Examiner Corcuma The law requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaase or Injury thet initiated evants rasulting in daath) Last and -tran Due to (or as a consequence of) physician a s the buriel-Box 68760. Physician/Medical Dua to (or as a consequence of) ettending | for use as P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, 9 cate has been sig 24b. Were eutopsy findings available prior to Be Completed 24e. Wes en autopsy performed? completion of cause of death? 1 ☐ Yas 22 No this certificate 1 ☐ Yas 2 ☐ No Division of Vital director. 25. Wes casa rafarrad to medical examinar? 26. Place of Deeth (Chack only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA al or Attanding Physics after death.

In Director: After this ed in by the funeral d 27. Menner of Death 28e. Deta of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Tima of 28d. Describe how injury occurred Certification: 5 Panding Invastigation 1 Naturel 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 ☐ Sulcida 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital of within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et tha tima, data and placa, and dua to the ceuse(s) end mannar as stated.
2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edicai 29a. Certifiar completely 29b. Signatura end titla of cartifier 29d. Date signed (Month, Dey, Yeer) 29c. License number Hawed & Trulch of his 20 Feb- 1998 T) 12194 Md 30. Name and addrass of person who completed causa of death (Itam 23a) (Type, Print) 348 Mill ST HACERSTOWN Md 21740 R DRIXCh Jr HAROLD 32. Ragistrar's Signatura 31. Data filad (Month, Day, Year) State

wha Davidson-Randell

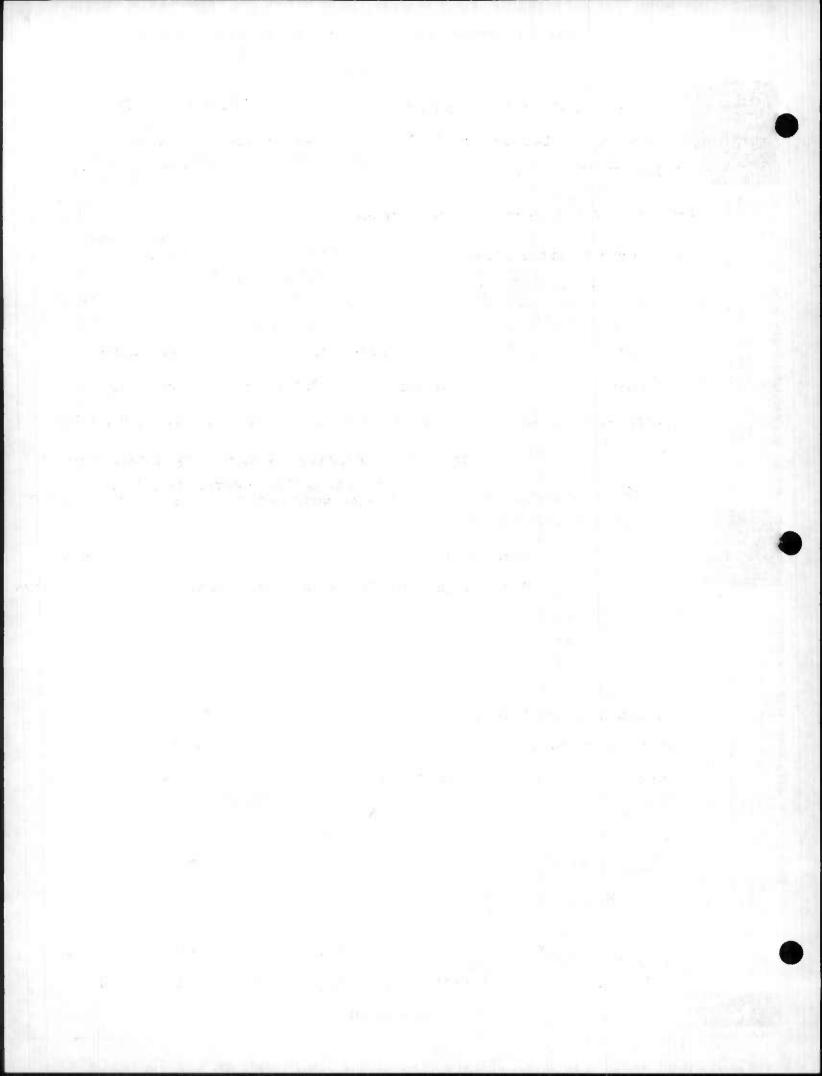
FEB 2 0 1998

Registrar



State of Maryland / Department of Health and Mental Hygiene 9 8

				,	C	ertificate d	of Death	R	eg. No.	U /	340
	Physic	ion	Decedent's Neme (First, Middle, Last,	15				2. Dete of Dee	th	Vees	3. Time of Deeth
ı,	/Medi		ROSE MARGAF		HMAN		,	Februar	y 11, 1	998	14:26
	Exami	ner	4a. Fecility Neme (If not institution, give				4b. City, Town, or		4c. County		
-	5		Washington C 5. Social Security Number 6. Sec			u) If Under 1 Y	Hager ear if Under 24 Hrs			hingt	e (Stete or Foreign
	Funerai Director			M 2 ₹ 65	Yrs.	Months De		8. Date of Birth Month Dey May 9,	1932	Mary.	land
	yland		10a. Stete 10b. County	10c. Ci	ty, Town or I	Location				10d.	Inside City Limits
	Man Man	ţ	Maryland Washin	gton H	lager	stown					1 XYes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Coo	ie	1	0g. Citizen of V	Vhet Country	?
	23a		119 North Potom	ac Street			740		U.S.A		
Maryland 21215-0020	72 hours after death with the Manyland natural; or items 23a or 28s-f show of call Examiner must be notified at	by Funeral	11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Yeer or Dates:	I,S. 13	8. Was Decedent If Yes, specify (1 ☐ Yes 2)(☐	of Hispenic Origin? (S Cuban, Mexican, Puer No Specify:	(Specify Yes or No- orto Rican, etc.) 14. Rece - Americ Bleck, White, Specify: Wh			
2-0	72 hours	Completed	15. Decadent's Edu (Specify only highest grede		16e. Dec	edent's Usuel Oc	cupation	dring	16b. Kind of Bu	siness/Indus	itry
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7	filed within Hygiena. Ither than "		12 17. Fether's Name (First, Middle, Last)			Homema		- (Files A & C. dell.)	0wn		
and	S a b	Be C	Joseph		White		Cather	me (First, Middle, I	ve <i>iden Sum</i> am race	e) Kret	70 T
3	d 2 should b th end Mente 7 Is marked traumatic e	2	19a. informent's Name/Reletionship (Ty				reet and Number or Ri				
X	alth e 27 le		Larry J. Laugh				tomac Str				
ore,	m 0		20e. Method of Disposition	20b. I		position (Name o emetory or other			20c. Location -		
Ĕ	Pages nent of I ant: If ite ary or of		1 Buriai 2 Cremation 3 R 4 Donetion 5 Other (Specify)	-13-98 H	agersto	wn, Ma	aryland				
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		21. Signeture of Funeral Servica License	Brahen		Andrew 1	dress of Facility Coffman	Funeral	Home,	Inc.	J 01740
	-		23a. Pert1. Enter the diseese, or complishock, or heert failure. List only on	cetions thet capacid the deel	th. Do not e	nter the mode of	Antietam dying, such es cardie	correspiretory em	nagers co est,	Ac	d. 21740
	Physician /Medicai		Immediete Ceuse (Fine)							Or	tervei Between nset end Death
	Examiner	1	diseese or condition resulting in death)	, Pneumonia	or as a cons	equence of):				4	days
	D #	ner		Chronic o			pulmonar	y disea	se	ma	ny year
	tificate be executed g physicien and as the buriel-trensit	Physician/Medical Examiner	Sequentielly list conditions,). ————	or es e conse						
60,	cien d	<u>e</u>	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury							1	
68760,	physicate sthe	dic	thet initiated events resulting in deeth) Lest	Due to (o	r es e conse	equence of):					
		Me.	L a								
ROX	death e atter	clar	Pert II. Other significant conditions con	tributing to dooth but not and	ultime in the		alice to Dead	non piere			
J.	than than than than than than than than	hys			uiting in the	underlying couse	given in Perti.				e cause of death?
	gned be da	by F	Ischemic Heart	Disease							,
Records,	been s	Completed	Hyper Lipidemi	.a				24e. Was a perform		aveile	autopsy findings ble prior to letion of cause oth?
ř	te h	Com	Chronic Suppur	ative Mast	oidit	is		1 □ Ye	s 2 No	1 □ Y	es 2 No
Vital	Physicien: The this certificate and director, per	Be	25. Was case referred to medical exeminer?					eth (Check only on	e)		
0	Physician: this certific ral director,	2	ILI 165 ZIM NO			BILL SUL DOA		lome 5 ☐ Reside			
	After funer	on	27. Manner of Deeth 1 Naturei 5 □ Pending	28e. Date of injury (Month, Dey Year)	28b. Time injury		njury et Work?	28d. Describe ho	w Injury occurr	ed	
-	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completaly filled in by tha funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At he building, etc. (Specif.	ome, farm, s		I Yes 2 No ce	28f. Location (St City or Town	reet and Number, Stete)	er or Rural Ro	oute Number,
	To the Hospital of within 24 hours at To the Funeral D completaly filled I	edical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	lcian: To the best of my kno ner: On the basis of examine end menner stated.	wledge, dee tion end/or i	oth occurred et the nvestigation, in m	e time, dete end place by opinion, deeth occu	a, and due to the ca arred et the time, de	use(s) and ma ate and piaca, e	nner as state	d. e cause(s)
	within To th	Me	29b. Signature end title of certifier			29c. Lic	ense number	2	9d. Dete signed	(Month, Dey	r, Year)
			John South	'A CO		D1	2924		Februar	y 11.	1998
			30. Name end eddress of person who co								
			John J. Sest			reet, H	agerstow	n, Mary	land 2	21740	
	Sta	ite	31. Dete filed (Month, Day, Yeer)	32. Registra 's Signa	ture	Bruta 00					

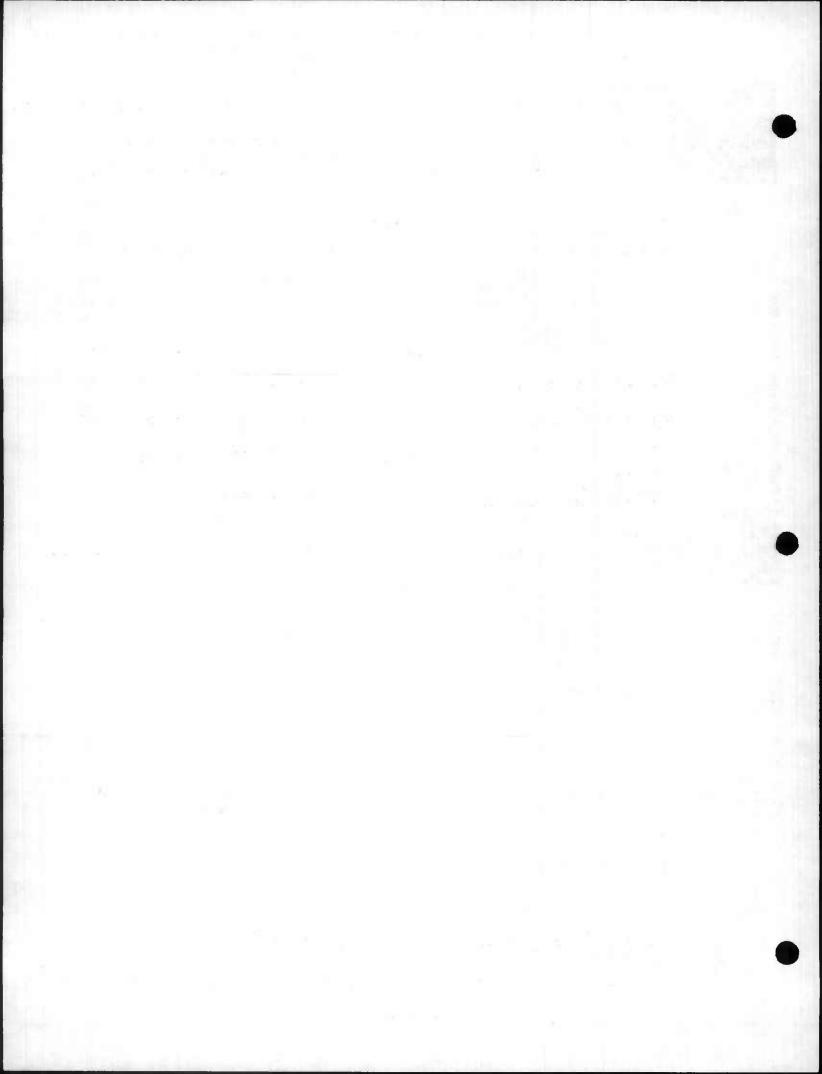


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of the **Physician** Feb. Noah Sterling Long 1998 8:50a.m. /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1935 Reese Road Westminster Carroll Words Days Hours Min. 8 Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Birthplaca (Stata or Foreign Country) 10XM 2□ F 216-22-1743 Yrs. Director 94 Oct. 19, 1903 Maryland Usual Rasidance of Dacedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yas 2 ☑ No Carrol1 Westminster 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? ò 1935 Reese Road 21157 United States Items 23a Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ଛੈ No if Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Biack, Whita, atc. should be filed within 72 hours efter ond Mentel Hygiens.

marked other than "naturel", or Ita 1 Navar Marriad 2 Marriad Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: by 31 Widowad 4 □ Divorced Specify. White Completed 15. Dacedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Collega (1-4or 5+) Mechanic Automobile permit. Peges 1 and 2 should be file Department of Health end Mentel Hy Important: If item 27 is merked other any Injury or other traumatic event. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Noah Jackson Long Anna Rebecca Houck 19a. informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zlp Coda) Paul Rill/P.O.A. 218 Dutrow Rd. Westminster, MD 21157 20a. Mathod of Disposition 20b. Piaca of Disposition (Nama of cematary, cramatory or othar place) 20c. Location - City or Town, Stata POBurial 2 Cramation 3 Removal from Stata Carrollton Cem. 2/24/98 4 ☐ Donation 5 ☐ Othar (Spacify) Finksburg, MD 21. Signatura of Fanaral Sarvica Licensee 22. Nama and Addrass of Facility 91 Willis Street Westminster, MD 21157 Myers Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Cartiopul monay Examiner Examiner (oronay arten Village ician end buriel-trensit Tha law requires that the deeth certificate be executed Dua to (or as a consaquance of) Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiatad evants rasulting in daath) Last Years physician s the buriel Box 68760. Is chemic Cardiomyopath Physician/Medicai 950 P.O. | signed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 Yas 2 No Aftar this certificate 1 Yas 2 No Hospital or Attending Physicien: 1 24 hours efter deeth. Funeral Director: After this certifica 25. Was casa rafarrad to madical Be 26. Piaca of Daath (Check only ona) Other: 4 Nursing Homa 5 Testidance 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. injury at Work? 5 Panding invastigation 1 Natural 1 Yas 2 No 2 Accidant 6 Couid not be datarmined 3 Suicida 28a. Piace of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) in by 4 ☐ Homicida filled 24 hours e 29a, Cartifier 🔀 Cartifying Physician: To tha bast of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated within 24 hor To the Fune completely fi (Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) 6569 N. Charles St. Svite GOD Bultimore neg 21204 0. m. D. 31. Data tiled (Month, Day, Yaar) 32. Registrar's Signatura State John Studen Radell Registrar

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month LOUISE MOYER Feb 24 1998

1120

9. Birthplace (Stata or Foreign

White

10d. Inside City Limits

Approximate Interval Batween Onset and Death

1 ☐ Yes 2√ No

1. Decedent's Name (First, Middle, Last) **Physician** BESS /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood Retirement Center Washington Williamsport | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth (Month, Day Year Apr 28, 7. Aga (In yrs. last birthday) 3. 1895 Bath, **Funeral** 1□ M 2□xF 172-10-7324 102 Yrs. Director Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examiner name be notified at Director Washington Williamsport 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 16505 Virginia Ave 21795 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - Americen indlan, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mentai Hygiene. Important: if them 27 is marked other than "natural", or any injury or other traumatic event, the traumatic of the space. 1 Never Married 2 Married 1 ☐ Yes 2 █ No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Oliver John Lindaman Mary Lisberger 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. Clayton Moyer/Son 10774 Country Club RD Waynesboro PA 17268 20a. Method of Disposition 20b. Piace of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Buriai 2 🗵 Cremation 3 🖾 Removal from State Cumberland Valley Crematorium 2/25 Waynesboro PA 17268 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funarai Sarvice Licensea 22. Name and Address of Facility Grove Funeral Home, Inc. 50 S BRoad ST Waynesboro PA 23a. Part1/Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical mass probably cardiona Immediate Causa (Final disease or condition resulting in death) Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying

Due to (or as a consequence ot):

an/Medicai	Cause (Disease or injury that initiated evants resulting in death) Last	C. Due to (d	or as a consaquence of):		
by Physician/M	Part ii. Other significant conditions con	ntributing to death but not re-	sulting in the undarlying	ceuse given in Part I.	23b. Did tobacco use co 1 ☐ Yes 🔅 No	ntribute to the cause of death? 3 Probably 4 Unknown
Completed b	Arteroschood Chrol care				24a. Was an autopsy performad?	24b. Were autopsy tindings available prior to completion of ceusa of death?
Be C	25. Was cese reterred to medicel			28. Place of De	eath (Check only one)	
To	examiner? 1 ☐ Yes 2 DXNo	Hospital: 1 Inpatient 2	ER/Outpatient 3 [OCA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Otr	ner (Specify)
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	stigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	red
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, tarm, street, factorify)	ry, office	28f. Location (Street and Numb City or Town, State)	ber or Rural Route Number,

3 Suicide 6 Could not be Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifian (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and title of 29c. Licansa number

32. Registra Signature

FEB 2

Higes ten and 31. Date tiled (Month, Day, Year)

State Registrar

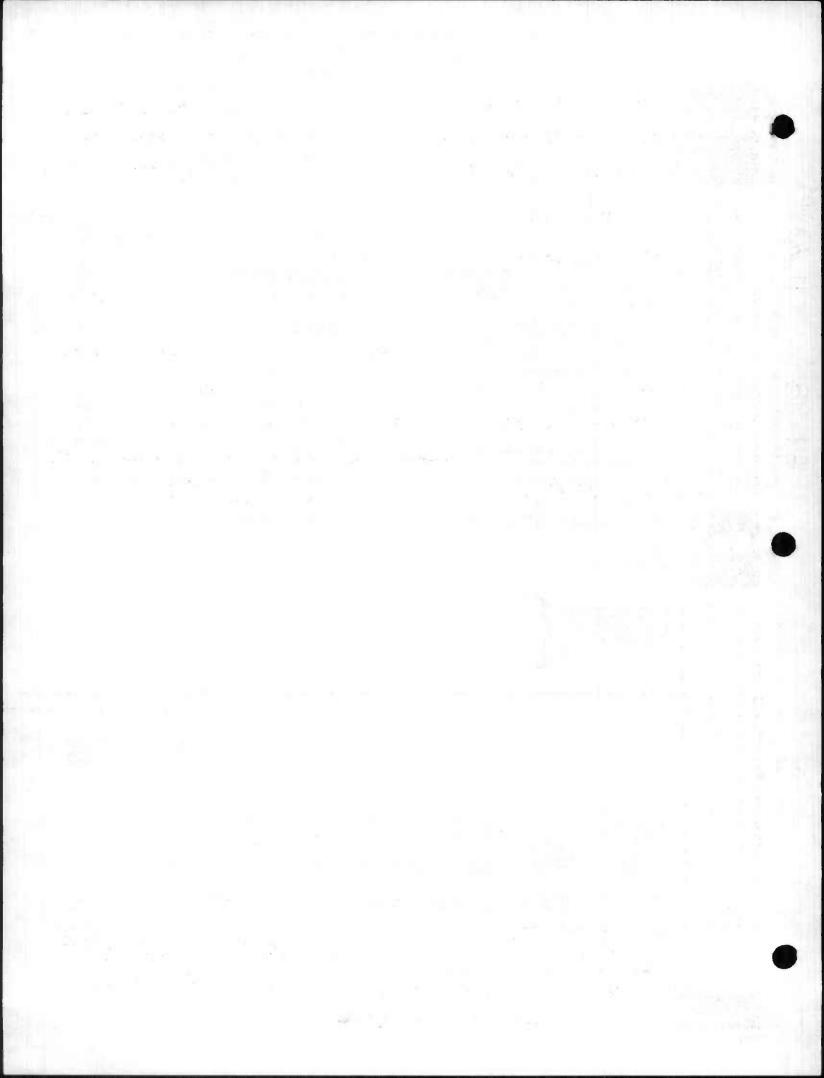
Medical

Records, P.O. Box 68760,

Athending

To the Hospital within 24 hours a To the Fu

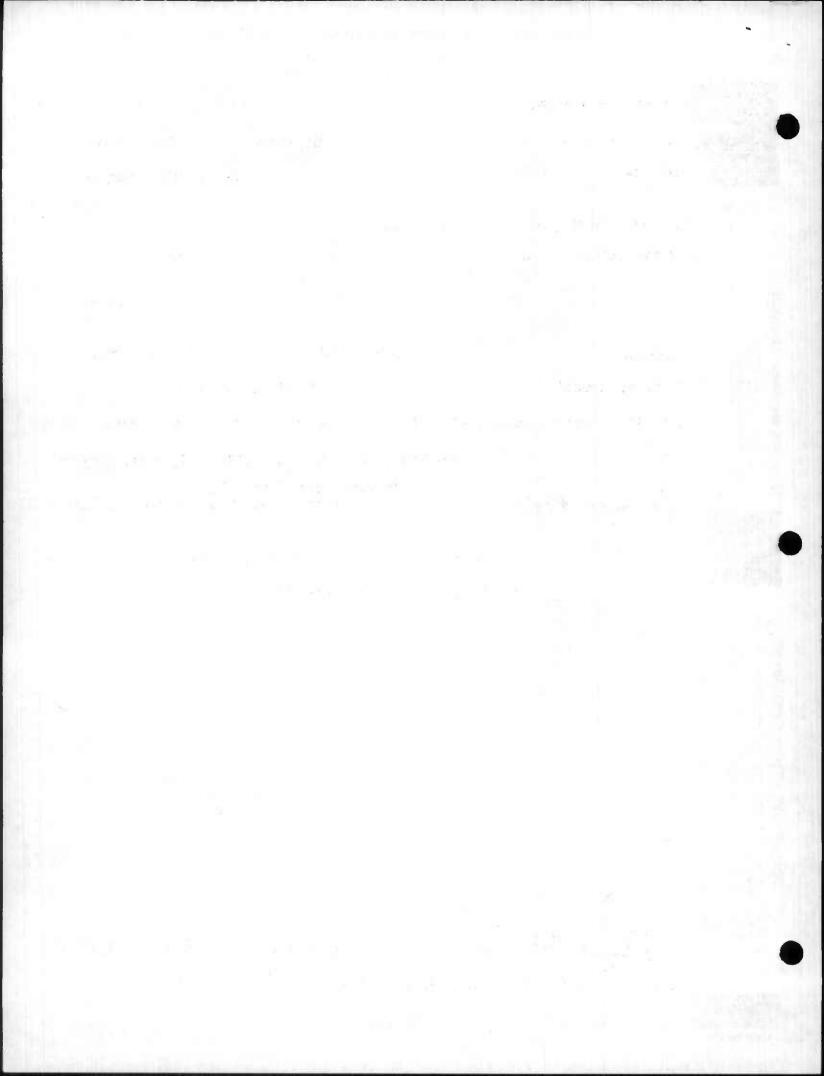
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month February 17,1998 **Physician** LEE RAYMOND MUMMERT 9:00 AM /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street end number) 4c. County of Deeth **Examiner** 10814 Coffman Avenue Hagerstown Washington If Under 1 Year Months Deys If Under 24 Hrs. Hours Min. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 M 2□ F 215-18-2761 75 Yrs. **Director** June 3, 1922 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location rai", or items 23s or 28s-f show Exposiner result be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 10814 Coffman Avenue permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Example conse. 21740 U.S.A. Funeral 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black. White, etc. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 ☐ Never Married 2 ☑ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerk Unknown Aircraft Mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Irvin M. Mummert Edith M. Forsythe 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Lucille Turner Mummert / Wife 10814 Coffman Avenue Hagerstown, Maryland 21740 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Shanktown Cemetery Feb. 21,1998 Big Pool, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Thompson Funeral Home Inc. 23a Part . Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. 13607 National Pike Clear Spring, Maryland 21722 Approximate Interval Between Onset and Death **Physician** Adenocarcinoma of the Esophagus /Medical Immediate Ceuse (Final disease or condition resulting In death) year Examiner Due to (or es e consequença of): Prostate Cancer Physician/Medical Examiner iclan and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In death) Lest Division of Vital Records, P.O. Box 68760, physician the buria Due to (or es e consequence of): 88 for use signed by the a Part II. Other aignificent conditiona contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No Certification: To After this funeral 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the ceuse(s) end manner stated. within 2 To the the 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) February 18, 1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud Smithsburg MD 21183 Dwayne Shuhart 22911 Jefferson MD 31. Dete filed (Month, Dey, Year) State while Davidson Registrar . 28



State of Maryland / Department of Health and Mental Hygiene Q S Certificate of Death 1. Decedent's Neme (First, Middle, Last)
Marie Evangeline Mason 2. Dete of Deeth 3. Time of Deeth Month **Physician** February 8:26 PM 12,1998 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Homewood Home Washington Williamsport 8. Dete of Birth (Month, Dey, Year) Feb. 21, 1927 5. Social Security Number 095-28-8494 If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1 □ M 2 ☑ F 70 Yrs Director Eden, Idaho Usuel Residence of Decedent the Maryland 10e. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at WV Jefferson 1 ☐ Yes 2X No Director Charles Town 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 25414 908 Belvedere Heights U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Meritel Stetus 14. Rece - American Indien, Bleck, White, etc. NOWYes 2 No If Yes, Give Yeer or Dates: 1949-1951 1 Never Merried 2 Married 1□ Yes 2□No þ Specify: White 3 □ Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry se filed within 7 el Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Unknown Registered Nurse Hospital 17. Fether'a Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be filt Department of Heelth and Mentel Hy Important: if Item 27 is marked oth any Injury or other traumatic event potes. Emil Martens Lena Petersen 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Ste P.O. Box 696, Charles Town, W 25414 19e. Informent's Neme/Reletionship (Type, Print) Marcia A. Householder-Daughter 20b. Plece of Disposition (Name of 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Pleasant View Memory Gardens 2/15/98 Martinsburg, WV tXXBuriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Melvin T. Strider Co., Inc. P.O. Box 388, Charles Town, WV 25414

23a. Part1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Examiner Examiner physician and the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thal initieted events resulting in deeth) Lest Physician/Medical Due to (or es e consequence of) 980 ed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yee 2 No 3 Probably 4 Unknown þ been si 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed certificate hes 1 ☐ Yes 2□N 1 □ Yes 2 □ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Netoral 5 Pending 1 Yes 2 No death. Investigetion 2 Accident or Attend efter death Director: 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital c within 24 hours er To the Funeral D 29e. Certifier (Check only one) 1 🕒 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted. Medical 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred et the lime, date and piece, end due to the ceuse(s) and menner stated. 29b. Signature and the of 29c. License number

muse of deeth (Item 23e) (Type, Print)

lia Davidson

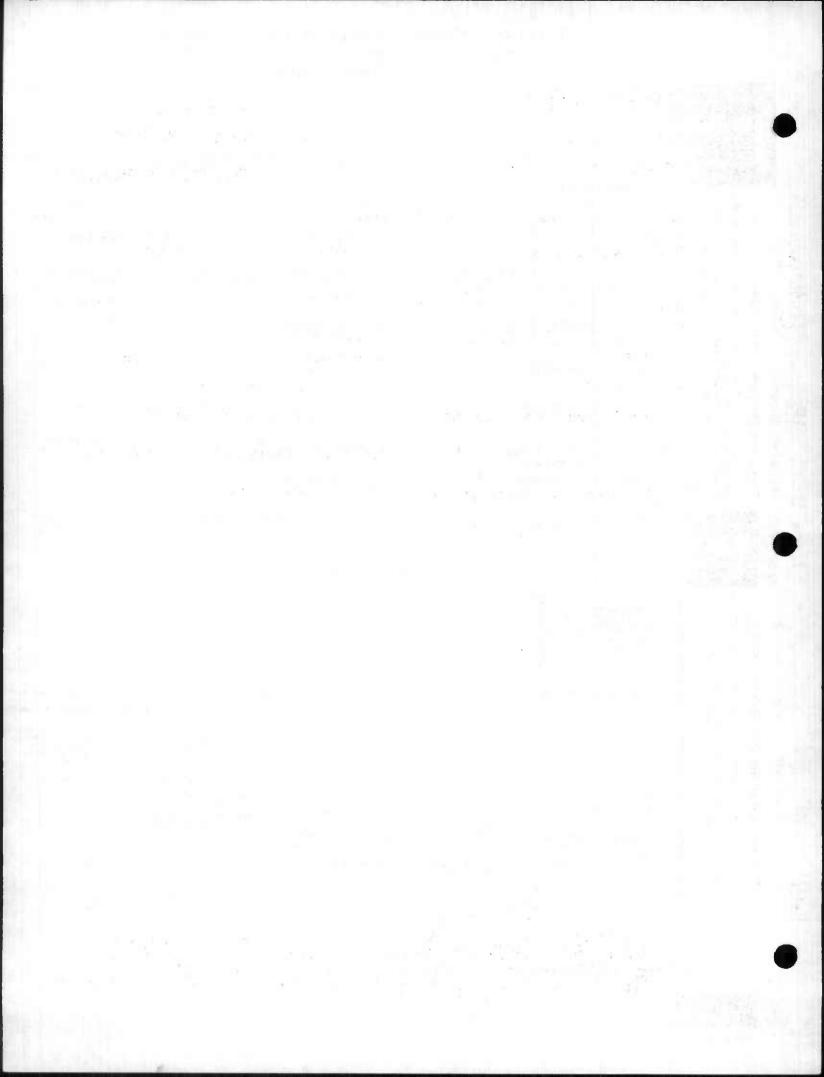
32. Repistrar's Signeture

State Registrar

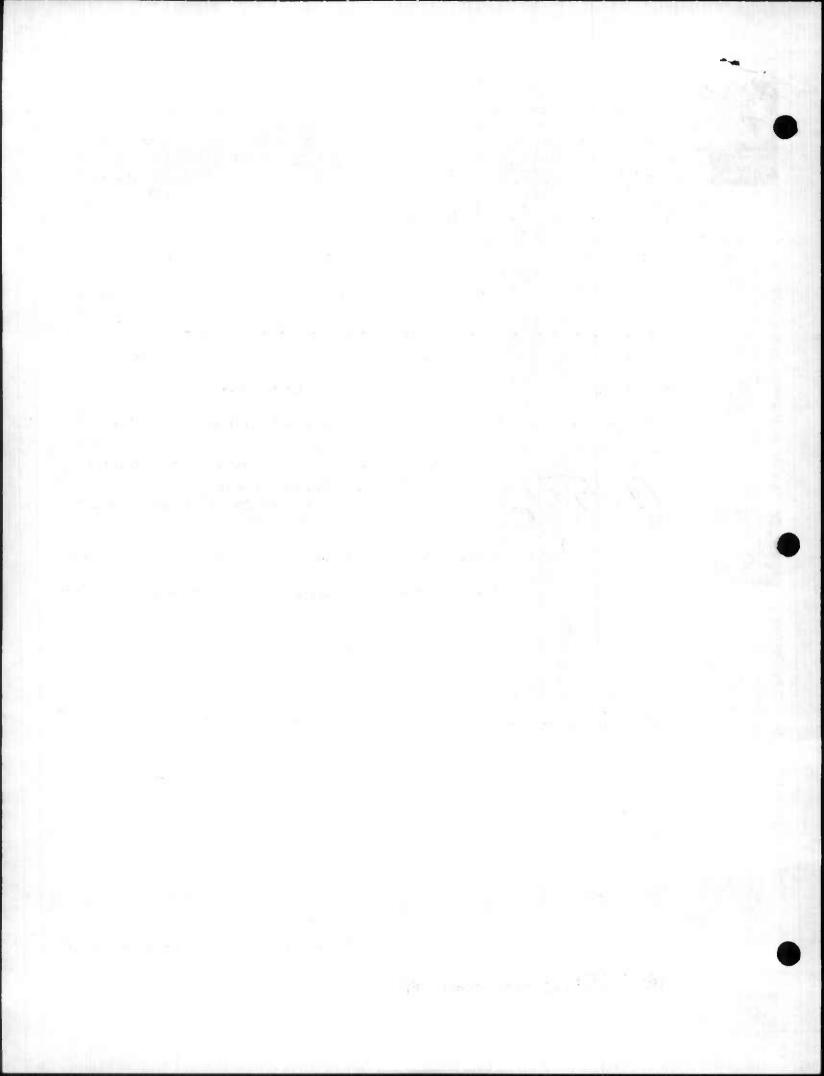
31. Dete filed (Month, Dey, Year)

FEB 17

1998



						Ce	ertificate of	Death		Reg. No.	U	1353		
Physic /Med		1. Decedent's Nen		Last)					2. Date of De Month Feb.	oth Day 24	Year 1998	3. Time of Death 12:12 a.m.		
Exam		4e. Facility Name			um <i>ber)</i>			4b. City, Town, or Lo			y of Deeth			
-		5. Social Security I	anor Nursi	ing Home	7 Age //	n yrs. lest birthday	/) If Under 1 Yeer	Hagerstown If Under 24 Hrs.			ington	and (Chata as Familia		
Funera Director		205-36-789 Usual Residence)4	1□M 2ÅF		93 Yrs.	Months Days		8. Date of Bird (Month, Da 07-25-19	y, Year) 04		aca (Stete or Foreigr ry) boro, PA		
show		10a. State	10b. County		10	c. City, Town or I	ocation		10d. Inside City I					
e Mar	Director	MD	Washingt	On		Hagerstown	1				1 ☐ Yes 2[
vith th	Dire	10e. Street and Nu	ımber				10f. Zip Code			10g. Citizen of What Country?				
s 23s	erai	14014 Mars	h Pike	12. Wes De	andont Fue	- in 11 C 40		742-1638		USA		a la dia a		
TO-DOZO 72 hours efter death with the Manyland 72 hours efter death with the Manyland *naturel*, or frems 23s or 28s-f show social Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Mar 3 □ Widowed	ried 2 Marrie	Armed F	Forces? 2 X No Sive	rin U,S. 13	. Was Decedent of P If Yes, specify Cub 1 ☐ Yes 2√√No	Hispanic Origin? (Spien, Mexican, Puerto Specity:	Rican, etc.)	Special	ce - America ick, White, e fy: wh			
within ena.	Completed	(Spe		grade completed	d) (1-4or 5+)	16a. Dec. (Giv life.	DO NOT use retire	pation during most of work d)	ing	16b. Kind of E		ustry		
e filed Il Hygie other	Be Co	17. Father's Name	(First, Middle, L	ast)		nomen	aker	18. Mother's Name	e (First, Middle,		ome			
Maryiand d 2 should be file th and Mental Hy 7 is marked othe traumatic event,	To B	Homer Ju	stice					Ella Adde	lsberger					
2 should and Men is marke		19a. Informant's N				19b. Mei	ling Address (Street	end Number or Run		er, City or Town	Code)			
1 end 2 Health am 27 i		Richard Ni		(s	son)			ve., Hagers						
permit. Pegas 1 and 2 Department of Health, Important: if Item 27 is any injury or other tra			☐ Cremation 3	B □Removal from	n State		position (Neme of emetory or other ple	ca)	Date	20c. Location - City or Town, State				
nit. Postante		4 Donation 21. Signature of Fi	5 □Other (Spe			Lincoln C	emetery 22. Name and Addre		2-26-98	Chamberst	mbersburg, PA.			
Depa Impo		10/	10 A	17				. Geisel Fu	neral Hon	ne Inc.				
Physician		333 Falling Spring Road, Chambersburg, PA, 17201 23a. Full: Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Shock, or heart failure. List only one cause on each line. Approximate Intervel Betwee Onset end Dea												
/Medical Examiner	_	Immediate Cause (Finel disease or condition resulting in death) e. Seven Cannany Artery Driver Trees (Finel disease)												
Examino		resulting in death)			Due	to (or as a conse	equenca of):				1			
uted	Examiner			b	ANT		entiz a	indiana	nen ?	sine		m		
axect an end rial-tra	Exa	Sequentially list co if any, leading to Ir ceuse. Enter Und Cause (Disease or	nditions, nmediate eriving		Due	to (or as a conse	equenca of):							
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		Toosking in doutry		d							-			
daath cert e attandin ed for use	lan			U										
	Physician/M	Pert II. Other signi	ficent condition	s contributing to	death but no	ot resulting in the	underlying cause giv	ven in Part I.				the cause of death?		
gned by the	by Pi	Kyper	Limina						10	Yes 2□ No	3 ☐ Prob	ably 4⊠Unknow		
aw requir	Completed b									an autopsy med?	con	re autopsy findings ilable prior to apletion of cause eath?		
The law	Com								101	res 2 □ No	1 🗆	Yes 2□ No		
Vitali ilclan: The certificata rector, pag	Be	25. Wes case references	red to medical					26. Place of Death	n (Check only o	ne)				
Physician: this certific	5	1 Yes 2			I tnpatient	2 ER/Outpetie	ent 3LI DOA	her: 4 Nursing Ho)		
Attanding F ir death. ector: After by the funer	tion	27. Manner of Dea 1 ☑Naturel	n 5 ☐ Pending investige		e of Injury onth, Day Ye	er) 28b. Time Injury	Wo	ryat rk? IYes 2 □ No	28d. Describe h	now Injury occu	rred			
5 4 . 4	Ca	2 ☐ Accident 3 ☐ Suicide	6 Could no	t be 28e. Plea	e of Injury -	At home, farm, s			28f. Location (S		ber or Rural	Route Number,		
Attandi r death. ector: A by tha fu	=	28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)								vn, Stete)				
tal or Attanding is efter death. al Director: After led in by the fune	Certification:													
he Hospital or Atta in 24 hours effar de he Funeral Directo pletely filled in by th	edicai	(Check only	1∰ Certifying 2□ Medical Ex	kerniner: On the I	basis of exa	mination and/or li	th occurred at the tin	me, date and place, a opinion, death occurr	and due to the ded et the time,	cause(s) and m dete end pleca,	anner as sta , end due to	ated. the cause(s)		
To the Hospital or Attanding I within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral	Medical Certifi	(Check only	2 Medical Ex	keminer: On the l end ma	basis of exa nner stated.	mination and/or li	nvestigation, in my o	opinion, death occurr se number	ed et the time,	dete end pleca, 29d. Date signe	end due to	the cause(s) Day, Year)		
To the Hospital or Atta within 24 hours effer de To the Funeral Directo completely filled in by th	edicai	(Check only one)	2 Medical Ex	kerniner: On the I	basis of exa nner stated.	mination and/or li	nvestigation, in my o	opinion, death occurr	ed et the time,	dete end pleca,	end due to	the cause(s) Day, Year)		
To the Hospital or Atta within 24 hours efter de To the Funeral Directo completely filled in by th	edicai	(Check only one) 29b. Signature and 30. Name and addi	d title of certifier	no completed cau	basis of exanner stated. Ouse of death	mination and/or li	29c. Licens D (opinion, death occurr se number	ed et the time,	dete end pleca, 29d. Date signe	end due to	the cause(s) Day, Year)		



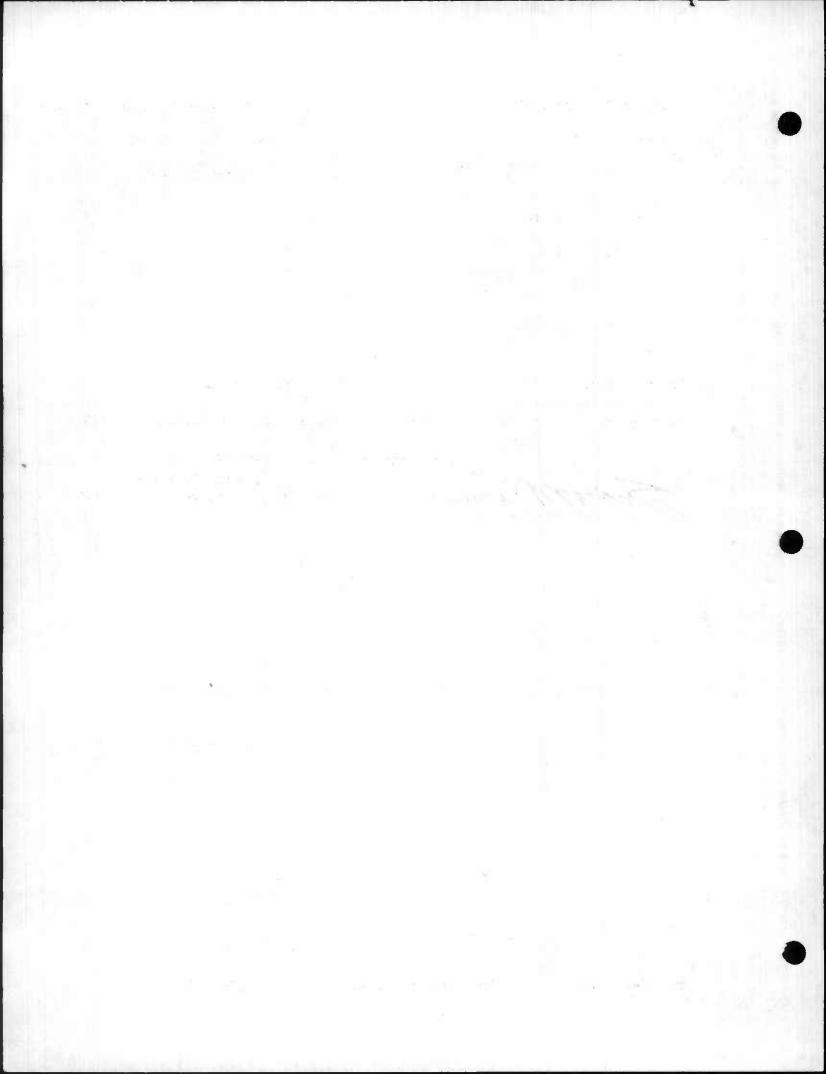
NAME: Luretta Blanche Poole

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Luretta Blanche POOLE 24, 1998 February 5:20 PM /Medicai 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Reeders Memorial Home Boonsboro Washington If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Funerai Birthplace (State or Foreign Country) Months Days Hours 1∭ M 2□ F 212-14-7433 88 Yrs. Director March 22,1909 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location Items 23a or 28a-f show ther mant be notified at 10d. Inside City Limits Director Washington 1X Yes 2 No Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11 W. Baltimore St. 21740 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 1∑No If Yes, Give Yeer or Dates: 11. Maritai Stetus Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, item 27 is marked other than "natural", or iten other traumatic event, I've Medical Examiner Black. White, etc. 1 Never Married 2 ☐ Married by 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Pages 1 and 2 should be filed within nent of Haalth end Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) owner restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Roy G. Powell Mary Delaney 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Haalth er Important: If item 27 is any injury or other trau Margaret E. Moore - daughter 20920 Twin Springs Dr., Smithsburg, Md. 21783 Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Buriai 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 2-27-98 Hagerstown, Maryland 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Onset and Deeth **Physician** /Medical Immediate Cause (Finei disease or condition resulting in death) myelars **Examiner** Due to (or as a consequenca of): Elheropeleroles The lew requires that the death certificate be executed wancell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest pue use as the buriel-trar Due to (or as a consequenca of) Division of Vital Records, P.O. Box 68760. been signed by the attanding physician should be detached for use as the burie Physician/Medical Due to (or as a consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by Completed 24b. Were autopsy findings evailable prior to 24a. Was en autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: Be 25. Was case referred to medical 26. Piace of Death (Check only one) Other: P₀ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day Yeer) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural daath. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide in by t 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D32518 120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Guedenet 100 Geeting Lane, Keedysville, MD 21756/301-432-2222

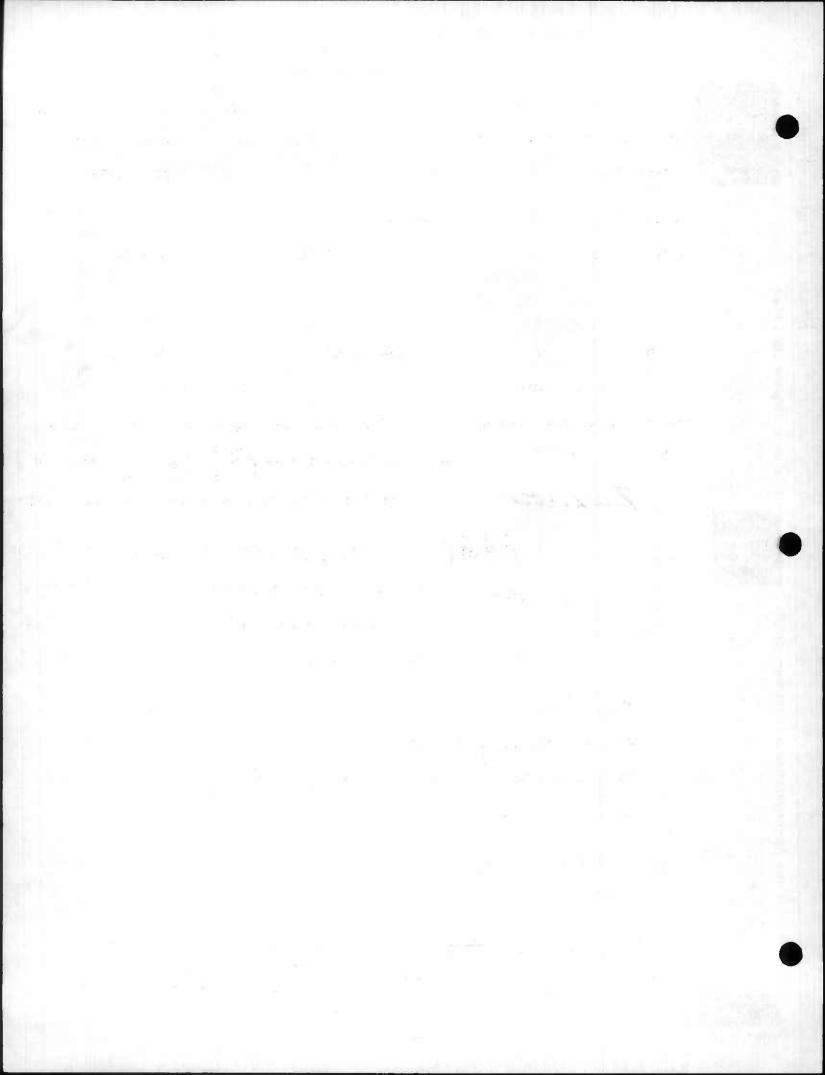
32. Regintrar's Signature

State Registrar 31. Dete filed (Month, Day, Year) FEB 2 7 1998



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(First, Middle, Last) Catherine	Virginia	PARKER		2. Dete of Deeth Month February	Dey ZO,	1998

				Certific	ate of	Death		Reg. No.	0 0	1355
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/Medical	Cathe	0	ia PAR	KER			Februa	ury 20,	1998	6.27 pm
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or led	Maryland Wash	nington	Hager	stown					"	1 □ Yes 203
be netfred Director	10e. Street and Number	8001	Mageri		Zlp Code			10g. Citizen of	What Coun	try?
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r tems 234	11. Meritel Stetus	12. Wes Decedent Armed Forces?	Ever in U,S.	13. Was De	cedent of F	dispenic Origin	? (Specify Yes or Puerto Rican, etc.)	No- 14. Ra	ce - America	
by E		arried 1 Yes 2 1	No			Specify:	derio Filodia, etc.)		iy: Whi	
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To	19e. Informent'a Name/Rejetion		401	Maltin Add	nna /6+	and then to		Moore	- Otesta T	Code
trau	Mrs. Helen Edwa						or Rural Route Num e, Hagers			
other	20e. Method of Disposition	arab, adagnee	20b. Plece o	Disposition (Neme of		Dete	20c. Location		
٨٥	1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (3 Removel from State		emetery, crematory or other place) Feb. 23						
Injury	21. Signeture of Funerel Service		Cedar			Lal Par ess of Fecility		Funera		Marylan
ong Ong	· 7	1.1 7.0								
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the funeral cation:	27. Menner of Deeth 1 Platurel 5 Pend	28e. Dete of Injur (Month, Des		Fime of njury	28c. Injur Wor	ry et rk? Yes 2 □ No		how injury occu	irred	
by the	3 ☐ Suicide 6 ☐ Could		ury - At home, fa :. (Specify)				28f. Location	(Street end Num own, Stete)	ber or Rura	Route Number,
completely filled in	29a. Certifier 1 Certify	Ing Phyaician: To the best of Examtner: On the basis of	f my knowledge	, deeth occurr	ed et the tir	me, date and p	plece, end due to the	e ceuse(s) end m	nanner as sto	eted.
- 6 B	one)	end menner sta	ted.							
de de	29b. Signature and this of certifier 29c. License number 29d. Date signed (Month,									Jev. Year)
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comple	1 Xuy	$it \leq 1$	J, M	·D.	Y	7115		7.	ner	8
comple	30. Name angladdress of person	n who completed cause of	eath (Item 23e)	(Type, Print)	1). D	7115	8 will	54.	110	8
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State Registrar	30. Name and address of participation of the partic	L. COP	RECE	(Type, Print) S, Un	D.	83 Da	8 enill gerst	St.	mo	8 2174



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death **Physician** Month Dav 12.52 mm Nettie Emily PHILLIPS 1998 /Medical Feb. 16 4a. Facility Name (If not institution, giva straat and numbar) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 7836 Abbott Drive Boonsboro

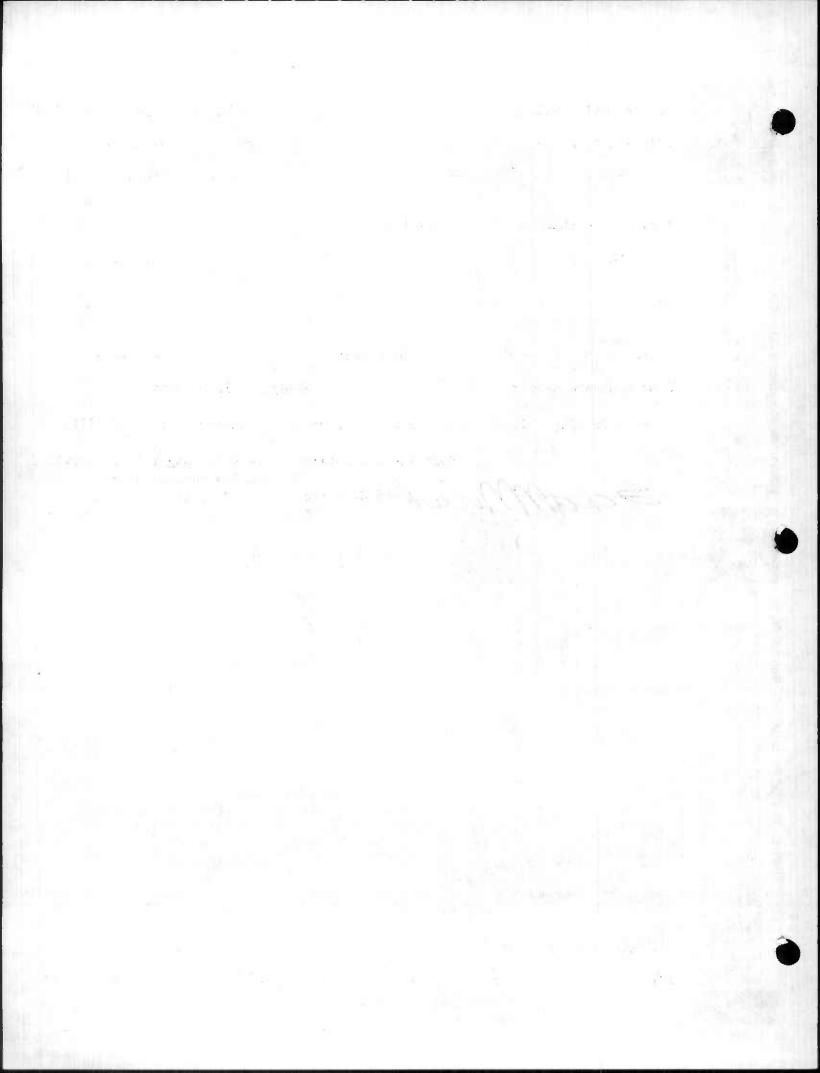
If Undar 24 Hrs.
Hours Min.

8. Data of Birth
(Month, Day, Year) Washington If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Months Days 1 M 2 X F Yrs Director 212-38-8787 1914 Maryland 8 Jan. Usual Rasidance of Decedant tha Maryland worls 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits "natural", or items 23a or 28a-f ahov Director 1 ☐ Yas 2 ☑ No Maryland Washington Boonsboro 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? daath with Funeral 7836 Abbott Drive 21713 U.S.A. Z. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yas, Giva Yaar or Datas: 14. Race - Amaricen Indian, Black, Whita, atc. 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) filed within 72 hours aftar 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 Completed by 3 Widowad 4 □ Divorced Specify: White permit. Pages 1 and 2 should be filed within 72 ho Departmant of Haalth and Mantal Hygiana. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, Ira Medical 15. Decedant's Education (Spacify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Her own home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be Joseph Howard Renner 2 Gladys Viola McFerrin 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) John W. Phillips, Jr. 7836 Abbott Drive - Son Boonsboro, Maryland 21713 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 N Burial 2 □ Cramation 3 □ Ramoval from Stata 4 Donation 5 Other (Specify) Rest Haven Cemetery 2-19-98 | Hagerstown, Maryland 32. Nama and Address of Facility Minnich Funeral Home 21. Signatura of Funaral Sarvice Licensaa 23a. Part1. Entar tha diseasa, or complications that causad tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 415 E. Wilson Blvd. Hagerstown, Md. 21740 Approximata Intarval Batween Onsat and Daath **Physician** /Medical Immadiata Causa (Final disaese or condition resulting in daeth) ASPIRATION PREUMONIA Examiner Due to (or as a consequence of): Physician/Medical Examiner DEMEN 71A Attending Physician: The law requires that the death certificate be axecuted bunal-tran Sequantially list conditions, if any, laading to immadiate ceusa. Entar Underlying Causa (Diseesa or injury that Initiated evants rasulting in daath) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown none Completed by 24b. Wara autopsy findings available prior to complation of ceusa of deeth? 24a. Was an autopsy performed? this cartificate has 1 Yes 22 No 1 ☐ Yas 2 ☑ No 25. Was cesa refarred to medical examiner? Be 26. Placa of Daath (Chack only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 2 Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) funaral 28a. Deta of Injury (Month, Day Year) Medical Certification: 27. Menper of Death 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? Aftar 1 Natural
2 Accident 5 Panding Injury NIA WIA death. Invastigation 1 Yas 2 No spital or Attendi nours after death. nersi Director: A filled in by the fi 6 Could not be datarminad 3 Suicida 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide N 24 hours a 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner es steled.

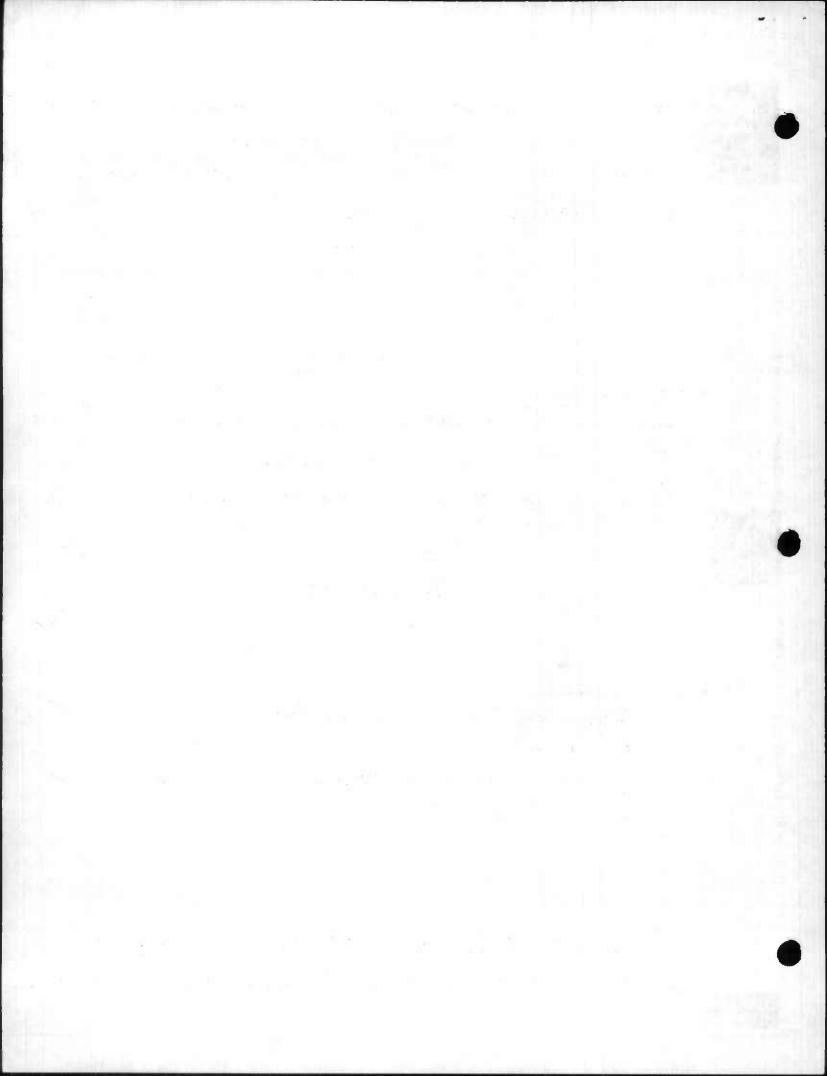
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the causa(s) and manner stated. 29a. Certifian To the Hosp within 24 hou To the Fune complately fil 29b. Signatura and titla of certifiar 29c. Licensa numbar 29d. Data signad (Month, Day, Year) D28365 2.17.98 30. Nama and addrass of person who complated cause of death (Item 23e) (Type, Print) HANZAR JSHAP 368 PHILL 368 MILL STREET HAUERSTOWN MO

State Registrar

31. Data filad (Month, Day, Year) FEB 18 1998 32. Registrar's Signatura Tandell

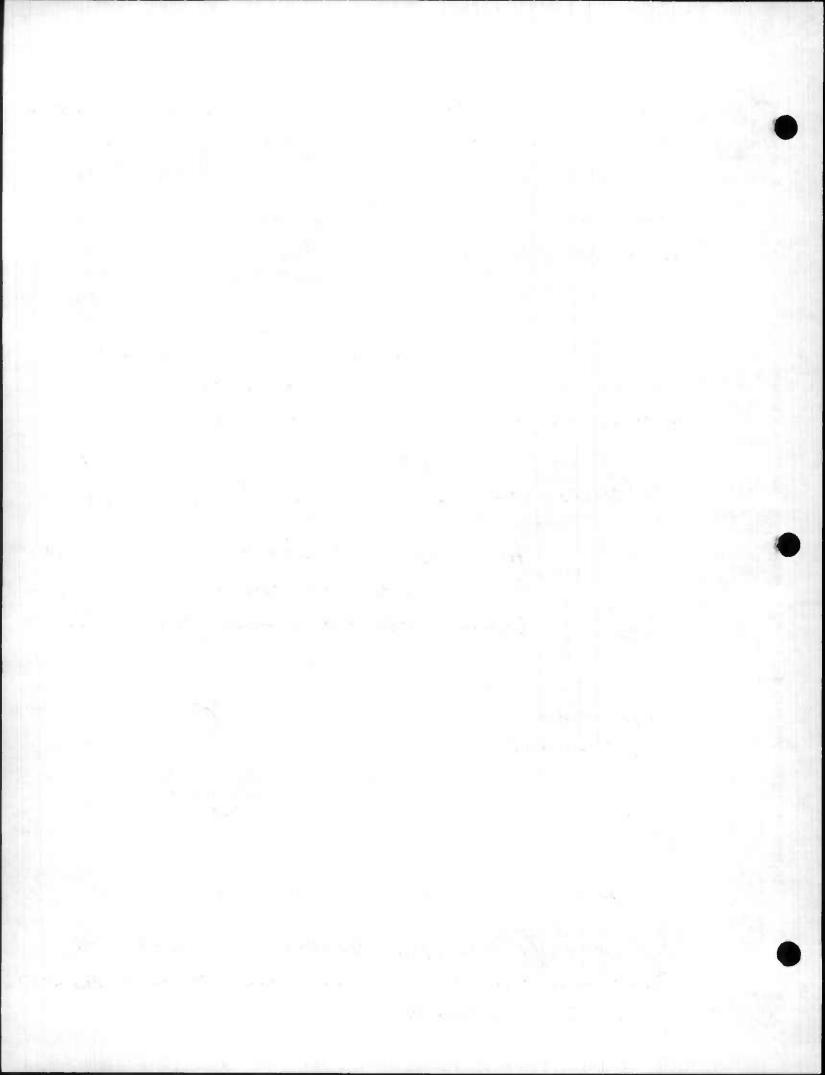


				State of Ivi	arylanu /	Certificate of		12	g. No.	0/35/
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		or	Usuel Residence of Decedent 10a. Stete Maryland Trede	erick	89			Jan. 2, 19	909	Connecticut 10d. Inside City Limits 1□ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	th with the P 23a or 28a-	al Director	10e. Street end Number 6527 Nighting	ale Cour	t	10f. Zip Code 217		10	Og. Citizen of W	
020	72 hours after death with the Maryland naturel; or items 23a or 28s-f show deal Exempter must be notified at	by Funeral	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 Y If Yes, Give Yeer or Detes:		13. Was Decedent of If Yes, specify Cu		pecify Yes or No- Rican, etc.)	Bleck	- American Indien, K, White, etc. White
Maryland 21215-0020	within	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondery (0-12)			Decedent's Usuel Occ (Give kind of work don life. DO NOT use retii	red)	king	16b. Kind of Bu	siness/Industry
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re, Mai	1 and 2 s Health ar em 27 to ther trau		19e. Informant's Name/Relationship Carl F. Pfist 20a. Method of Disposition	,,,,,	(Son)	of Disposition (Neme of	tingale	Ct., Ne	ew Mar	
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Box 68760,	leath certificate be axecuted attending physician and for use as the burial-transit	an/Medical Examiner	Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	b	Due to (or es e	consequence of): Consequence of): Consequence of):	(Aepinno	on)		Sdugo 6dug
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Division of	or Attending Phys after death. Director: After this In by the funeral di	Certification: To	27. Menner of Death 1 Neturel 2 Accident 3 Sulcide 4 Homicide	e Ope Diese of leis	y Yeer) 28b.	Time of 28c. Inj	ury et ork? ☐ Yes 2 ☐ No	ome 5 Reside 28d. Describe ho 28f. Location (Str. City or Town	w Injury occurre	
	in 24 hours in 24 hours the Funeral plataly filled	edicai	29e. Certifier 1 Certifying Ph (Check only one) 1 Medical Example	ysician: To the best of niner: On the basis of end menner sta	exemination er	e, death occurred at the nd/or Investigetion, In my	time, dete end plece, opinion, deeth occur	end due to the ce red et the time, da	use(s) end mer ite end place, a	nner as stated. nd due to the ceuse(s)
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	Str	te	30. Name and address of person who MRK P. Ruß. 31. Date filed (Month, Day, Year)	1 M.,) 32. Registr	eeth (Item 23e) 20/ 1 ar's Signature	(Type, Print) Thomas Vo	Thoson V.	n FREN	PERIUS	MU 21702
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State of Maryland / Department of Health and Mental Hygiene

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	Physic	an	Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month	th Day	Year	3. Time of Death
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	Exami	ner	4e. Facility Name (If not institution, give	The state of the s			4b. City, Town, or	Location of Death	4c. County	of Deeth	
			1632 NORTH MAIN				HAMPS'			CARRO	
	Funeral Director		5. Social Security Number 6. S 219-40-4298 Usuel Residence of Decedent	5ex 7. Age (In 7. Age	yrs. last birti	Months De		8. Dete of Birth (Month, Dey JUL 18	Year) 1945		lace (State or Foreign try) LAIND
	/land		10e. State 10b. County	10	c. City, Town	or Location				1	0d. Inside City Limits
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	leath with the Marylan ns 23s or 28s-1 show	Director	10e. Street and Number			10f. Zip Cod	9	1	Og. Citizen of \	What Coun	itry?
	h wit		1632 NORTH MAIN S	TREET APT 2			21074		US	A	
	dea dea	Funeral	11. Meritel Status	12. Wes Decedent Ever Armed Forces?	in U,S.	13. Was Decedent of	of Hispanic Orlgin? (Suban, Mexican, Puer	pecify Yes or No-		e - Americ	
21215-0020	hours efter death with the Manyland ural', or items 23s or 28s-1 show Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2√2 N		o rican, etc.)	lican, etc.) Black, White, et Specify: WH		
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	may 1 to 1 miles	Co	9			WAREHOUSE				LISHI	NG
and	D E D	Be	17. Father's Name (First, Middle, Last					ne (First, Middle,		10)	
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Maryland	Clone		19a. Informant's Name/Relationship (Meiling Address (Stre				State, Zip	Code)
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Baltimore			20a. Method of Disposition 1x Burial 2 Cremetion 3		cemeter,	Disposition (Name of , crematory or other p	olace)	Date	20c. Location -	City or To	wn, Stete
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Sal	permit. Pages Depertment of Important: If it any injury or once.		21. Signature of Funeral Service Licer	1 /) "	22. Name and Ad	dress of Facility	ELINE FUN	JERAT. H	OME	
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	deeth. Do n						Approximete Interval Between
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	/Medicai Examiner		Immediate Cause (Final disease or condition	Acute	myo	cardial	Intarc	tron		100	minutes
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00	Sian couriel		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury	Chrone	c OV	extracti	ve sulm	onary o	fislas	ce	Zuears
68760,	certificate be nding physicia use es the bur	edical	that initieted events resulting in death) Last	Due	to (or as e co	ensequence of):		1		1/	1
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Вох	v requires that the death cer been signed by the ettendir should be detached for use	Physician/		u							
P.0.	that the death led by the etter detached for u	ysic	Part II. Other significant conditions of	ontributing to death but no	t resulting In	the underlying cause	given In Part I.	23b. Did to	bacco uae co	ntribute to	the cause of death?
σ.	d by detec		Hypertensio	101				NEW YEAR	98 2□ No	3 Prot	ably 4 Unknown
of Vital Records,	signe t be d	by	Hypertension								
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=	The ate	Co						1 🗆 Y	s 2 000	10	Yes 2 No
/ita	Physician: The I this certificate he ral director, page	Be	25. Was case referred to medical examiner?					ith (Check only or	e) (
7	Physic this or	2	1 Yes 2 No		2 ER/Out	patient 3 DOA	Other: 4 Nursing H	ome Meside	ence 6 Oth	er (Specify	1)
L	fter t	on:	27. Menner of Death 5 Pending	28a. Date of Injury (Month, Day Yes	ar) 28b. Ti	me of 28c. In	njury at Vork?	28d. Describe h	ow injury occur	red	
Sio	Attending or death. Sector: After by the fune	catl	Accident investigation	1		M 1	Yes 2 No				
	or Attending efter death. Director: After I in by the fune	Certification:	3 Sulcide 6 Could not b 4 Homlcide determined	28e. Place of Injury - building, etc. (S)	At home, fan	m, street, factory, office	> 8	28f. Location (Si City or Town		er or Rura	l Route Number,
Ω	ital or ins effe ral Dir led in	Ce									
	To the Hospital or Attending Phywithin 24 hours effect death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Ph	yalcian: To the best of my niner: On the basis of exer and manner stated.	knowledge, mination and	death occurred at the for investigetion, in m	time, date and place y opinion, deeth occu	, and due to the c rred at the time, d	euse(s) and ma ate and place,	inner as st end due to	ated. the cause(s)
	withi To th	Σ	29b. Signature and title of cartifles	11			ense number		9d. Date signe		
			1 / street	Man	- 4	0 03	4298		2-2	23-	98
		-	30. Name and address of person who	pieted cause of death	(Item 23a) (T	ype, Print)	•	0			
			Robert Kass		532	Balton	rore Blu	d We	stmen	ter	98 MD 21157
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature					1	
	Registr	ar	FEB2319	198 Jaki dhu	older Ra	relath					
	IU 10 Day 600										



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death **Physician** Emma Catherine Rider cb /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington County Hospital Washington If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth Month Day, Year Aug • 27, 1908 9. Birthplace (Stata or Foreign Country) Mary I and 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1□M 2ØF Days Months 89 Yrs 218-01-0898 **Director** Usuel Residence of Decedent the Marylend 10a. Stata 10b. County 10c. City, Town or Location of 2 should be filed within 72 hours after death with the Manylen th end Mental Hygiene.

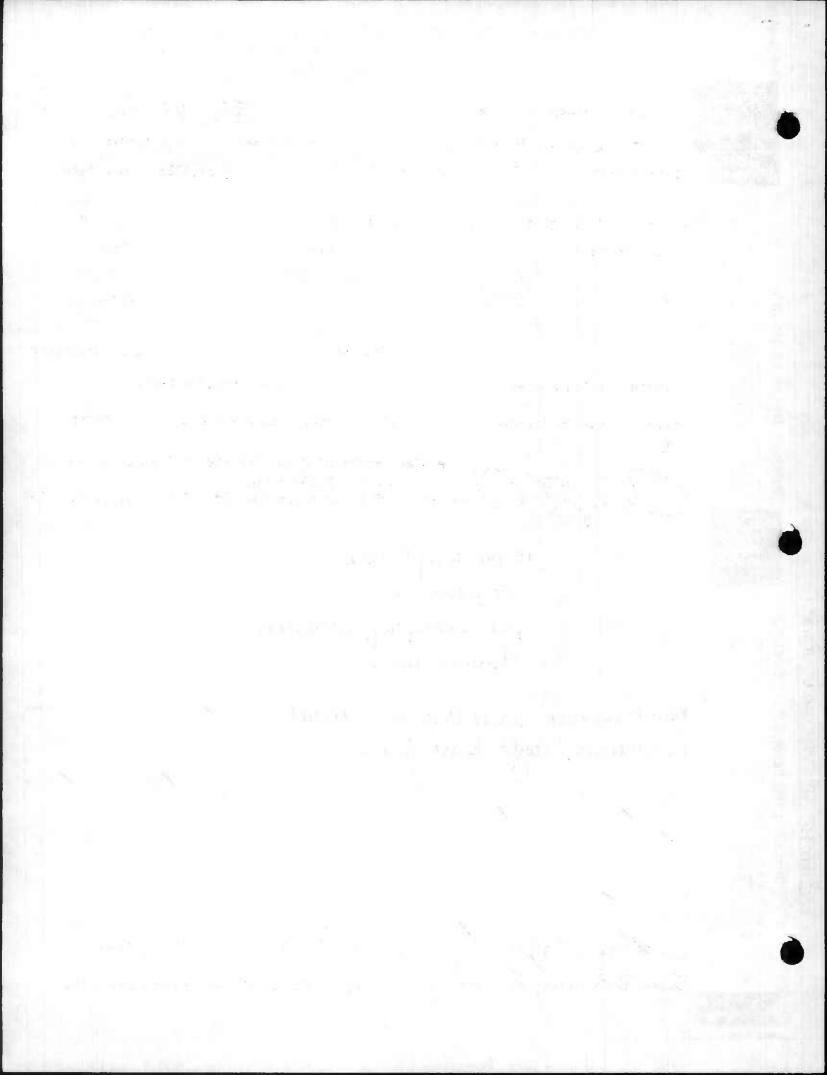
7 Is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Medical Examine must be notified at 10d. Inside City Limits 1 X Yes 2 □ No Directo Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 26 E. Church St. USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Datas: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Label Manufacturer 9 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middla, Last) Mammie Matilda Renner George Clinton Rhodes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Depertment of Health e Important: if item 27 la any injury or other trav 16134 Cloverton Lane Williamsport, MD Jeanne M. Wasson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Memorial Park 2-27-98 Williamsport, MD 21. Signature of Funeral Service 22 Name and Address of Facility Home 425 S. Conococheague St. Williamsport, MD 21795 raft1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure/List only one cause on each line. Physician /Medical Immadiate Cause (Final a respiratory tailure diseasa or condition resulting in death) Examiner Pulmenale Examiner ettending physician end for use es the buriel-transit Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disaase or Injury ulmonary homer leus con
Dua to (or as a consequence) po): Box 68760, Physician/Medical that initiated events resulting in death) Last Praceo Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. the 23b. Did tobacco use contribute to the cause of death? multi valvular heart disease 12 Yee 2 No 3 Probably 4 Unknown Records, Completed by 24a. Wes en eutopsy performed? 24b. Were autopsy findings avellable prior to completion of causa of death? 1 Yes 2 No certificate Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of Certification: 28c. Injury at Work? 28d. Dascribe how Injury occurred After i or Attending I 1 Natural 5 Pending s after death. 2 Accidant 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) 4 Homicide Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D43389 30. Name and address of person who co of death (Item 23a) (Type, Print) SUSAN B. Brinkley MD CAMPUS RD, SO TE 224 HABERSTOWN ND HIO MODICAL 31. Date filed (Month, Day, Year) FEB 26 32. Registrar's Signature State Sulia Davidson-Randole 1998

Registrar

Patherine

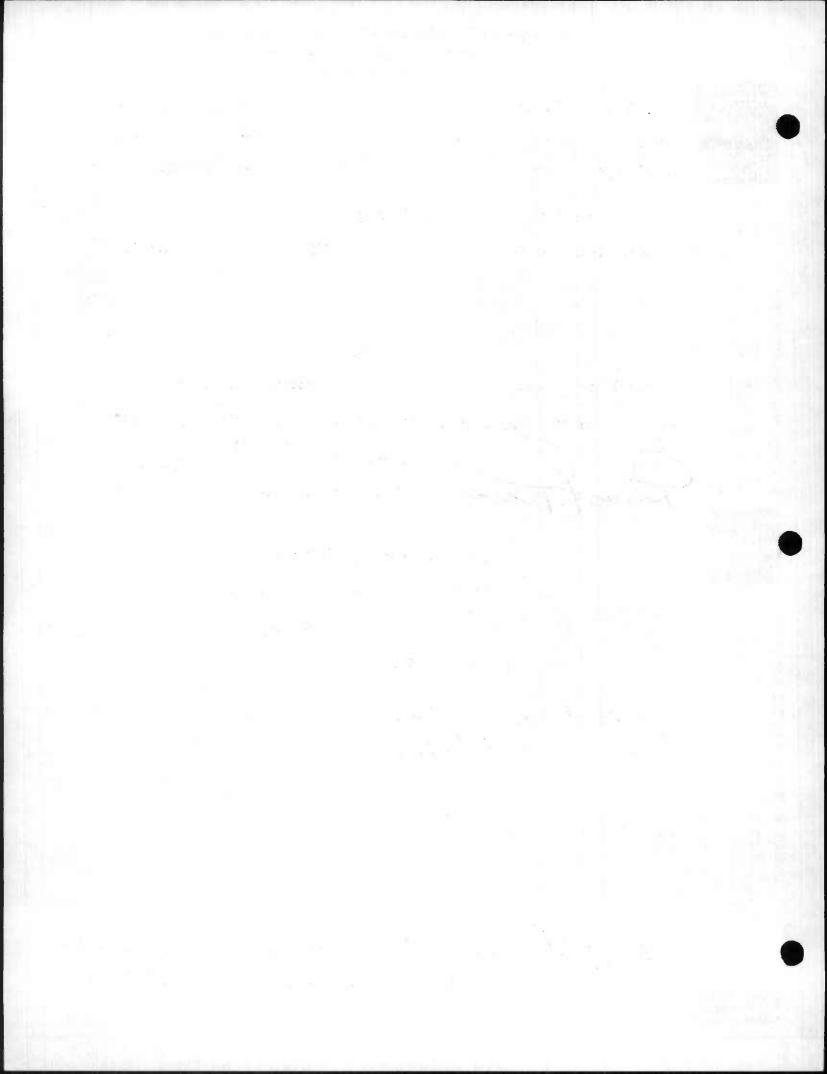
Emma



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death Day Yaar 20 1998 **Physician** Month 11:23 PM February Linda Lee Ridenour /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. July 17, 1936 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Mouy Land **Funeral** 1□M 2□F 215-34-2864 61 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours efter death with the Manyiar Depertment of Health and Mental Hygiene. Important: If them 27 is marked at than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example made to notified a 10d. Inside City Limits Washington Smithsburg 1 Yes 2 No Director 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 21783 13423 Kretsinger Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorcad Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Dacedant's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) Margaret A. Fritz Joseph Hamilton Pryor 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Walter E. Ridenour Sr. (husband) 13423 Kretsinger Rd. Smithsburg, Md. 21783 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stafe 24. Feb. 2 Cremation Ramoval from State on 5 Other (Specify) Cedar Lawn Memorial Park 1998 Hagerstown, Md. 21. Signature Sarvio 22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783 23a. Part 1. Enter the disaase, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsal and Death **Physician** /Medicai Immediate Causa (Final disease or condition rasulting in death) Examiner Examiner Insulin dependent ettending physicien end for use es the buriai-transit Saquentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760, ardiomyopa Physiclan/Medical signed by the ettending to be deteched for use Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Division of Vital Records, P.O. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Vascular þ 24b. Wera autopsy findings available prior to completion of causa of daath? 24a. Was an autopsy performed? Completed 2 No After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was casa referred to medical 26. Placa of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatienf 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 Yes 2 No completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 29a. Certifier 1 🖟 Certifying Phyaician: To the best of my knowladge, death occurred at the time, date and place, and dua to tha cause(s) and mannar as stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated. 29b. Signatura and lifle of certifier 29c. License number rson who complated cause of death (Itam 23a) (Type, Print) Smithsburg 21783 31. Date filed (Month, Day, Year) FEB 2 3 1998 32. Registrar's Signature State July Daydson-Randell Registrar

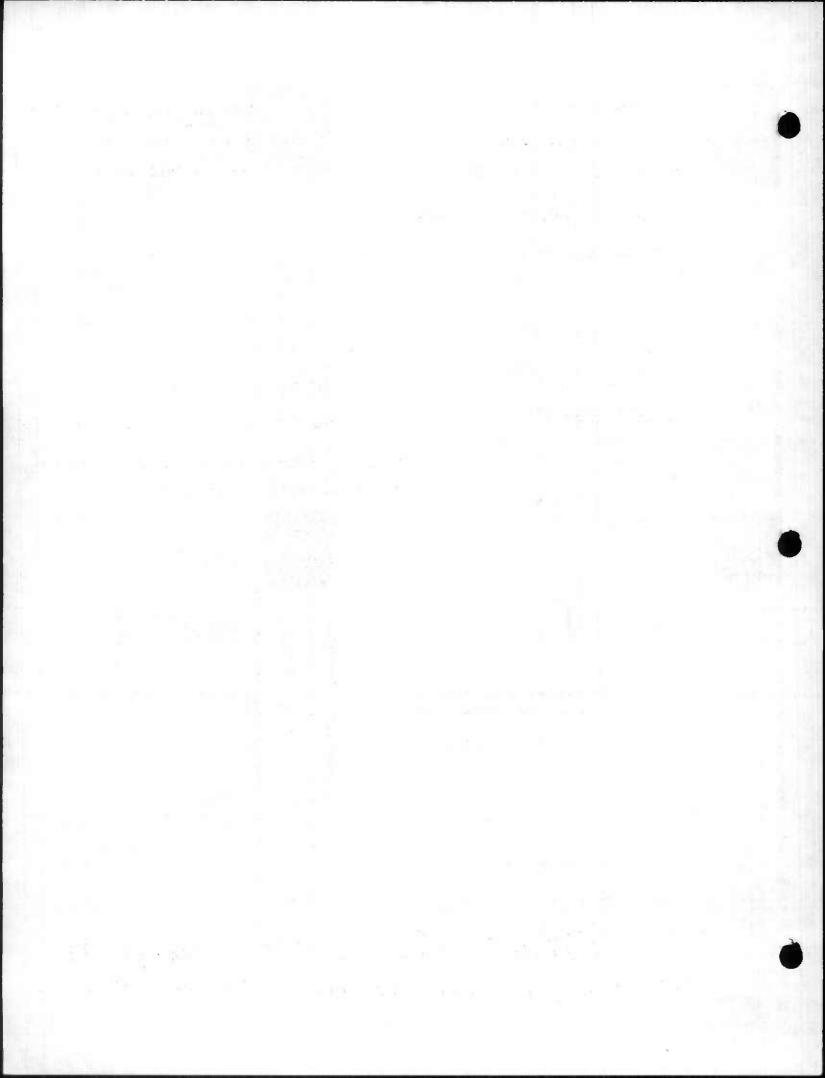


State of Maryland / Department of Health and Mental Hygiene

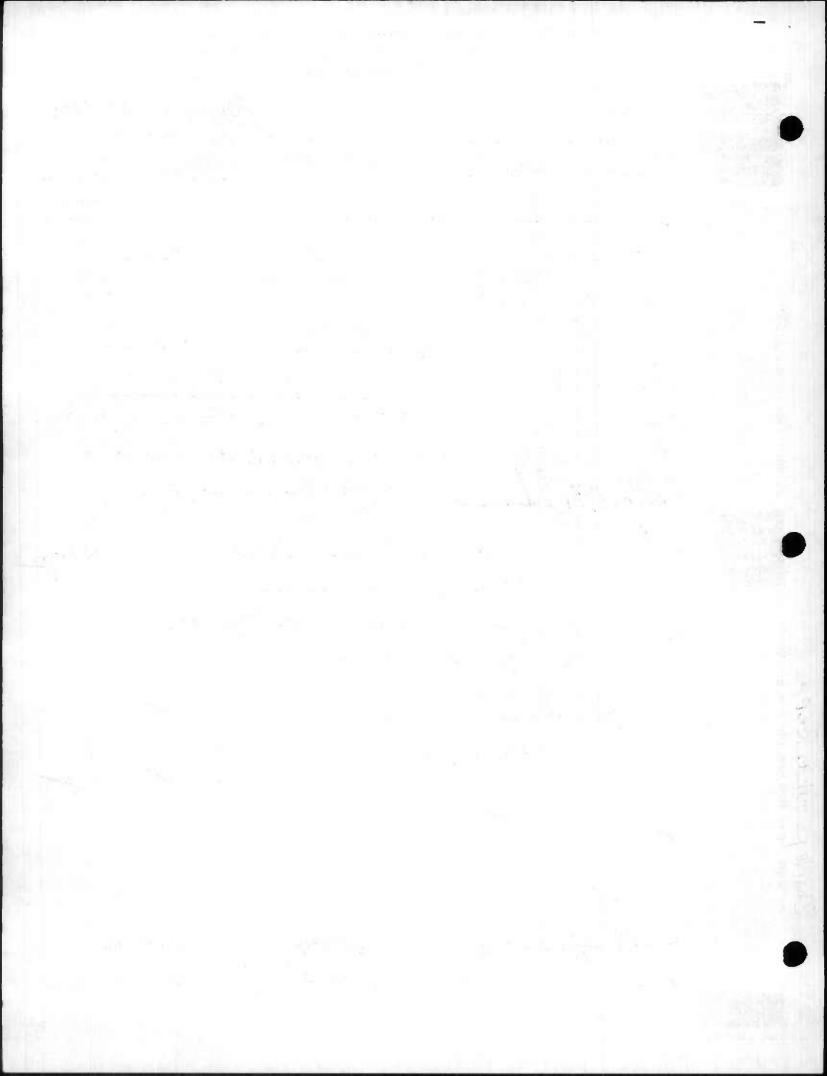
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 9:58 P.M Helen Jeanette Rudolph 4b. City, Town, or Location of Deeth 4c. County of Deeth 18, 1998 /Medical 4e. Facility Neme (If not institution, give street and number) Examiner Williamsport Williamsport Nursing Home Washington 8. Dete of Birth Month, Day, Year, June 24, 1912 if Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Sociei Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1□M 2QF New York 212-24-9442 85 Yrs. Director Usuel Residence of Decedent with the Meryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified as once. Maryland Washington Hagerstown Director 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 17630 Meadowood Drive 21740 USA Funeral 14. Rece - American Indien, Bieck, White, etc. 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give A Yeer or Dates: Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 No Specify by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Joseph Scalco Annetta Digiorgio 19e. Informent's Name/Reletionship (Type, Print)
James F. Rudolph 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 17630 Meadowood Drive Hagerstown, Maryland 21740 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney ValleyMemorial Gardens 2/21/98 Baltimore, Maryland 22. Name and Address of Fecility Gerald N. Minnich 21 Signeture of Funerel Service Licenses 305 N. Potomac Street weren Funeral Home Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** immediate Cause (Finel disease or condition resulting in death) /Medical 3 WEEKS Examiner Examiner ician and burlat-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the burial Box 68760. Physician/Medical 100 attending p signed by the at id be detached for P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Division of Vital Records. ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 s has 2 NO 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Hospital or Attending Physician: filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending Investigation within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homloide 29e. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. To the 29b. Signature and Ma of certif 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Overlook Dr. Boonsboro, 7542 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State Registrar

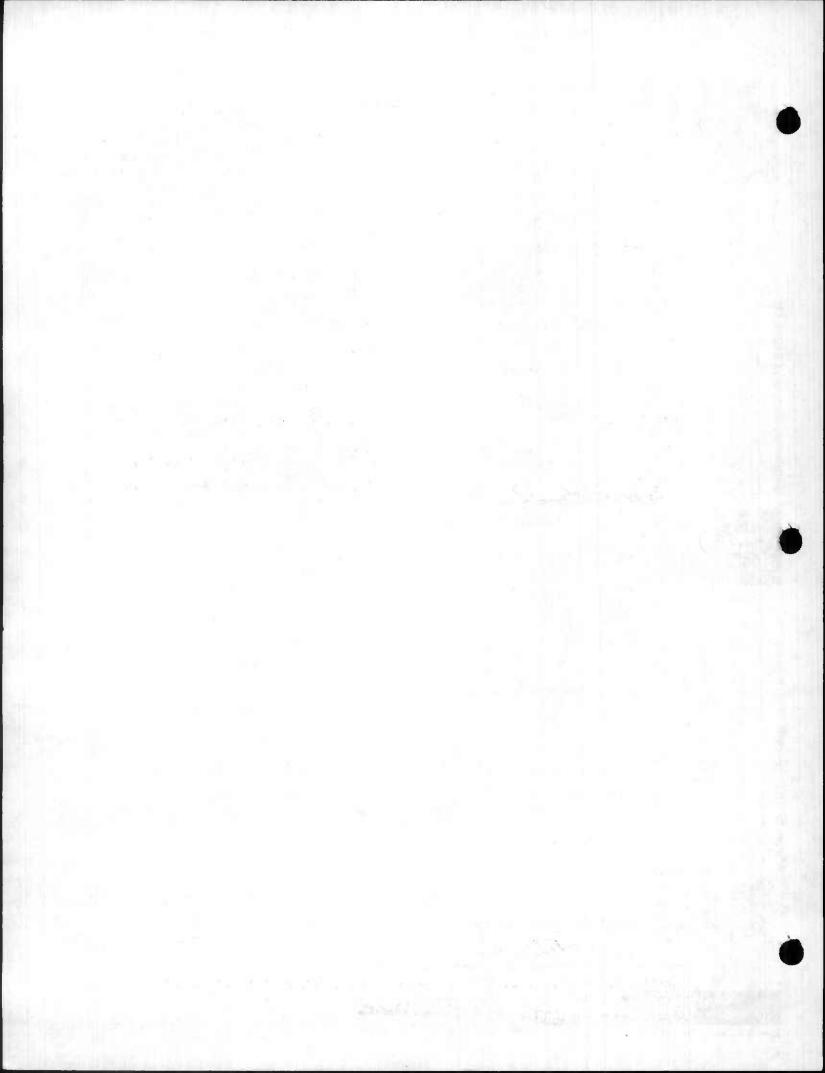
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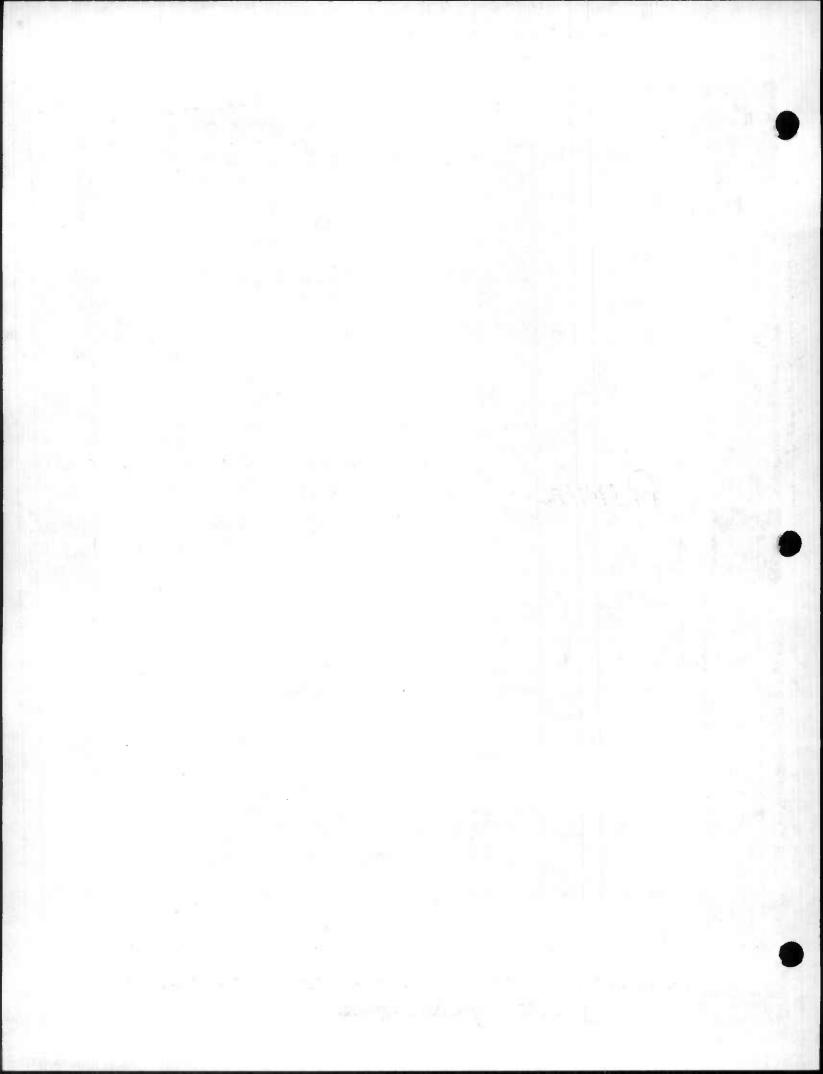
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4	Physici /Medic		Shirley Lo	uise Re	pp				Februa	N Dey /7	1978	1938
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d 21215-0020 ilied within 72 hours effer death with the Marylend	al', or items Examiner in	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Deceder Armed Forces 1 Yas 2 If Yes, Give Year or Detes	No		If Yes, specify Cut	Hispanic Origin? (Spen, Maxican, Puerto Specify:	Rican, etc.)	Bled	white,	etc.
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Baltimore,	nent of Heelth Int: If Item 27 I ury or other tre		20a, Method of Disposition 1 Suriel 2 Cremetion 3 4 Donetion 5 Other (Speci	Removel from Stet	e 20b. Ple	eca of Dispo metery, crei	osition (Name of metory or other pla Bridge	Cem.Feb.	Dete . 20,19	20c. Location -		
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			30. Neme end eddress of person who FNAN CLS CO	completed cause of	deeth (Item :	23e) (Type,	350 m	ie St-	Hager	Houn.	ME	121700
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10b. County Washingt		0c. City, Town or L Hancock					10d. Insida City Limits		
nd Number Irch Street,	Apt. 7	- /1-	10f. Zip Coo	21 7 50		10g. Citizen of What Country? U.S.A.			
atus Married 2 Married wed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yas ŽŽ No if Yes, Give Yaar or Dates:	ar in U,S. 13	Was Dacedent If Yes, specify (of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Race Blee Specify	e - American Indian, sk, White, etc. :- White		
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nt's Name/Relationship <i>(T</i> .e J. Gordon	ype, Print)			eet end Number or R 2, Berkele					
20a. Method of Disposition 1 Deurlai 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licenses 20b. Place of Disposition (Name of commeter, cremejory or other place). 21. Signature of Funeral Service Licenses 22b. Place of Disposition (Name of commeter, cremejory or other place). 21. Signature of Funeral Service Licenses						Teb. 19, 1998 Hancock, MD			
of Funeral Service Licens	100	10522 H	2. Name and Adelsley—	drass of Facility Johnson Fu n St., Ber	neral Ho	ome, Inc	•		
nter the disease, or comp r heart failura. List only o	lications that caused the	e death. Do not er	nter the mode of	dving, such as cardia	c or respiratory et	rest.	Approximate Interval Between		
ndition seath) ist conditions, to immediate Underlying se or injury vents ath) Last	b. non ins	e to (or as a conse sulin dep e to (or as a conse a to (or as a conse	endent quence of):	diabetes m	nellitus				
algnificant conditions co	ntributing to death but n	givan in Part I.		ntribute to the cause of death? 3 Probably 4 Unknown					
			24e. Wes	24b. Were eutopsy findings available prior to completion of cause of death?					
					1 🗆 Y	es 2XXVo	1 ☐ Yes 2 ☐ No		
referred to medical	15				ath (Check only o	ne)			
2 140	Hospitel: 1 Inpatient	2 ER/Outpatie	III SEL DON		lome A Resid				
Death i 5 Pending invastigation	28a. Date of Injury (Month, Dey Ye	ear) 28b. Time of injury		njuryat Nork? □ Yes 2 □ No	28d. Describe how injury occurred				
27. Manner of Death XM Natural 2							er or Rural Route Number,		
1☐ Certifying Phy 2 XHedical Exami	sician: To the best of m ner: On the basis of ex and mannar stated	time, dete end piece y opinion, deeth occu	e, end due to the durred at the time, d	cause(s) and madate end plece, a	nner as stated. and due to the cause(s)				
25. Was case referred to medical axaminer? ACT Yes 2 No 27. Manner of Death Mospital: 1 Inpattent 2 ER/Outpatient 3 DOA Other: 4 No Othe						r 29d. Dete signed (Month, Dey, Year) February 18, 1998			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
d N. Weeks,	M.D., 580	Northern	Avenue	, Hagersto	wn, MD	21742			
(Month Dev. Year) 32. Registrar's	d N. Weeks, M.D., 580 Northern	ddress of person who completed cause of death (Item 23a) (Type, Print) N. Weeks, M.D., 580 Northern Avenue	address of person who completed cause of death (Item 23a) (Type, Print) d N. Weeks, M.D., 580 Northern Avenue, Hagersto	ddress of person who completed cause of death (Item 23a) (Type, Print) d N. Weeks, M.D., 580 Northern Avenue, Hagerstown, MD Mogits, Gev. Year) 32. Registrar's Signature	ddress of person who completed cause of death (Item 23a) (Type, Print) d N. Weeks, M.D., 580 Northern Avenue, Hagerstown, MD 21742 Mogits, Sev. Year) 32. Registrar's Signature		



Physicia	n	1. Decedent's Name (First, Middla, La	ist)					2. Dete of Deeth Month	Dey	Yeer	3. Time of Deel			
/Medic		KATHRYN ELLEN	RADES					Februar		1998	1:45 A			
Examin	er	4e. Fecility Neme (If not institution, given	e street end numbe	r)			4b. City, Town, or I	ocation of Deeth	4c. County	of Deeth				
		REEDERS MEMORIAL					BOONSI			SHINGTO	ON			
uneral irector		5. Sociel Security Number 220–24–4639 Usuel Residence of Decedent	Sex 7.7 I□M 2፟፟⊈F	Age (In yrs 88	. lest birthday) Yrs.	If Under 1 Yeer Months Deys		8. Dete of Birth (Month, Day, JAN 4,	^{Yee} 7) 1910	9. Birthplec Country MARY	e (Stete or For LAND			
* 11		10a. Stete 10b. County		10c. C	ity, Town or Lo	cation				10d.	Inside City Lin			
등	tor	MARYLAND WASHIN	GTON			ROO	NSBORO			1 X Yes 2				
r 28	Director	10e. Street and Number				10f. Zip Code	HODORO	10	g. Citizen of V	Vhat Country	?			
23a or 28a-f show ust be notified at	aio	141 SOUTH MAIN S	TREET			2	1713		II	.S.A.				
A LINE	Funeral	11. Maritel Stetus	12. Was Deceder Armed Forces	f Ever in U	J,S. 13. V		Hispenic Origin? (S ean, Mexican, Puert	pecify Yes or No-	14. Rac	a - American				
al', or lit	þ	1 ☐ Never Merried 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorcad	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	No		Tes, specify Con		o micent, etc.)	Specify	ok, White, etc.				
fical	Completed	15. Dacedent's Ed (Specify only highest gre	ducation		16e. Deced	lant's Usuel Occup kind of work done OO NOT use retire	usinass/Indus	try						
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merk	2	WALTER DRAGIN	Total Delay		404 14-11	4.11		CH (UNKNO						
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em 2	-	20s. Method of Disposition 20b. Place of Disposition (Neme of Deta								443 City or Town,	Stete			
Important: If Item 27 is marked other than "natural", or Items any injury or other traumatic event, the Medical Examiner in once.		1 Bunal 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specif		Θ		netory or other ple	1							
	-	_ ^		MEA		GE MEM.	an of Facility.	/20/98 BA						
eny l		22. Signeture of Feelility Paul M Dean BAST FINEDAL HOME 7606 Old National Pike												
	23a. Pert 1. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart feilure. List only one cause on each line.													
edical miner	Immediate Ceuse (Finel disease or condition resulting in deeth) Due to (or es a consequence of):										~ 42			
d ansit	Examiner	Comment of the Commen	b. ————		or es e consequ					\ \ \ \ \	ره چې			
sician end bural-transit	Exa	Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Ceuse (Disease or Injury that initiated events		A			1 2							
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page 2	E O							1 ☐ Yes	2 4NO	1 🗆 Ya	as 2 No			
		25. Wes casa referred to medical examiner?					26. Placa of Dea	th (Check only ona)					
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the funera	ation:	27. Menner of Deeth 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation		ury ay Year)	28b. Time of Injury	28c. Injui Wor	ry et rk? Yes 2 □ No	28d. Describe how						
I Director: Af	Certification:	3 ☐ Suicide 6 ☐ Could not be datarmIned	28f. Location (Streat end Number or Rurel City or Town, Stete)			er or Rurel Ro	oute Number,							
4 9		29e. Certifier 12 Certifying Phy (Check only one) 2 Madical Example	ysician: To the best liner: On the basis of end menner s	of axamine	wiedga, deeth tion end/or inv	occurred et the tir estigation, in my o	me, date end place, prinion, deeth occur	end due fo the ceu red et the time, dat	use(s) end me e end plece, e	nnar as stete	d. e ceuse(s)			
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To the Funera		The state of a state of	- totale mo						D(8019 Feb 17, 1998					
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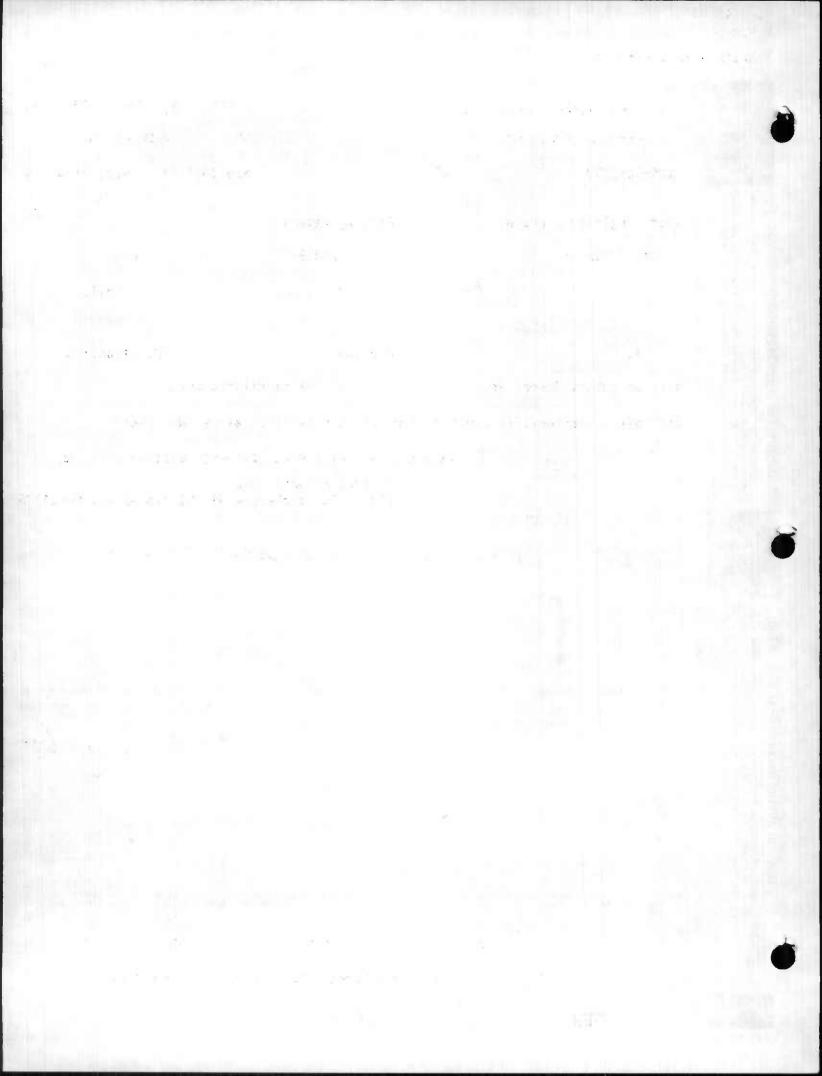
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WILLIAM ROBERT REYER JR.

State of Maryland / Department of Health and Mental Hygiene Q 8 07265

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sician ledical	William I	Robert	Rever	Jr.					ŀ	FEB.	16,]	2:10	
aminer	4e Fecility Name (If not i							4b. City, Town	n, or Lo	cation of Death	4c. (County of I	Death		
	WASHINGTO	N COUN	TY HOSI	PITAL				HAGER	STOV	VIN	W	ASHIN	IGION		
eral	5. Social Security Number			7. Age (In y	rs. last birthe	day) If Und	der 1 Year	If Under 24	Hrs.	8. Dete of Birth (Month, Day	Year)	9	Birthplece	(State or Fo	
tor	220-58-337	9 1	∆ M 2□ F		43 Yr	S.	is boys	Tiours		May 30,	954	W	lest \	/irgin	
	Usuel Residence of Dece	1111		140-	07 7-								1.01		
	10a. State 10b.	. County		100.	City, Town o	or Location					10d. Inside City 1 ☐ Yes 2				
cto	West Virgin	ia Be	rkeley					aters							
Director	10e. Street and Number					10f.	Zip Code			1	10g. Citizen of What Country?				
Ta la	Rt. 1 Bo	× 78				25419 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						US			
Funeral	11. Marital Status		Armed F	cedent Ever in forces?	U,S.	13. Was De If Yes, s	cedent of I pecify Cub	Ilspanic Origi an, Mexican, I	n? (Spe Puerto l	cify Yes or No- Rican, etc.)	1		American ! White, etc.	ndian,	
Be Completed by Funeral Director	1 Never Merried		If Yes, G			1□ Yes	2 No	Specify:				Specify:	White	9	
d by	3 Widowed 4 I		Year or	Dates:											
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To	William Rob			· ·	1					Idred Ba					
	19a. Informant's Name/F									I Route Numbe				de)	
	Bonita K. D		r/life			U. BOX		Falli	ng v	Vaters,		2541		Chaha	
5	20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cre		Removal from	State	cemetery,	crematory o	or other pla		1	Date			y or Town,		
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FEB 17 1930



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4b. City, Town, or Location of Death 4c. Co Jacob Guy Ridenour 1999 /Medical 4a. Facility Name (If not institution, give street end number) 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. J. Worth Pay, Year 35 5. Social Security Number 9. Birthpiace (State or Foreign Mougland 7. Age (In yrs. last birthday) **Funerai** 10XM 2□ F 62 218-30-8699 Yrs. Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Depertment of Heelih and Mental Hygiaes. Important: If them 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinet mail that notified and any injury or other traumatic event, the Medical Examinet. 10d. Inside City Limits Md. Washington Hagerstown 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21070 Leiters Mill Rd. 21742 U.S.A. Funeral 12. Was Decedenf Ever in U,S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 56-60 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2☑No Specify: White b 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Press Operator Printing Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Jacob Guy Ridenour Sr. Mary L. Wolfinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Joan V. Ridenour (Wife) 21070 Leiters Mill Rd. Hagerstown, Md. 21742 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Feb. 16, 94998 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Mt. Moriah Lutheran Cemetery Foxville. Md. Bonation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783 23e. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Physician /Medical immediate Cause (Final disease or condition resulting in death) Carline Arrest Instan T Examiner Physician/Medical Examiner attending physician end for use es the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 No Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Director: After 1 Natural 5 Pending investigation 1 Yes 2 No efter deeth. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled I 29a. Certifier 1 🖳 Certifying Phyelcían: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and plece, and due to the ceuse(s) and manner steted.

Boulevard

29c. License number

29d. Date signed (Month, Dey, Year)

State

(Check only one)

29b. Signature and title of certifier

Marns

22911 Jefferson

30. Name and address of person who completed ceuse of death (item 23e) (Type, Print)

#49793

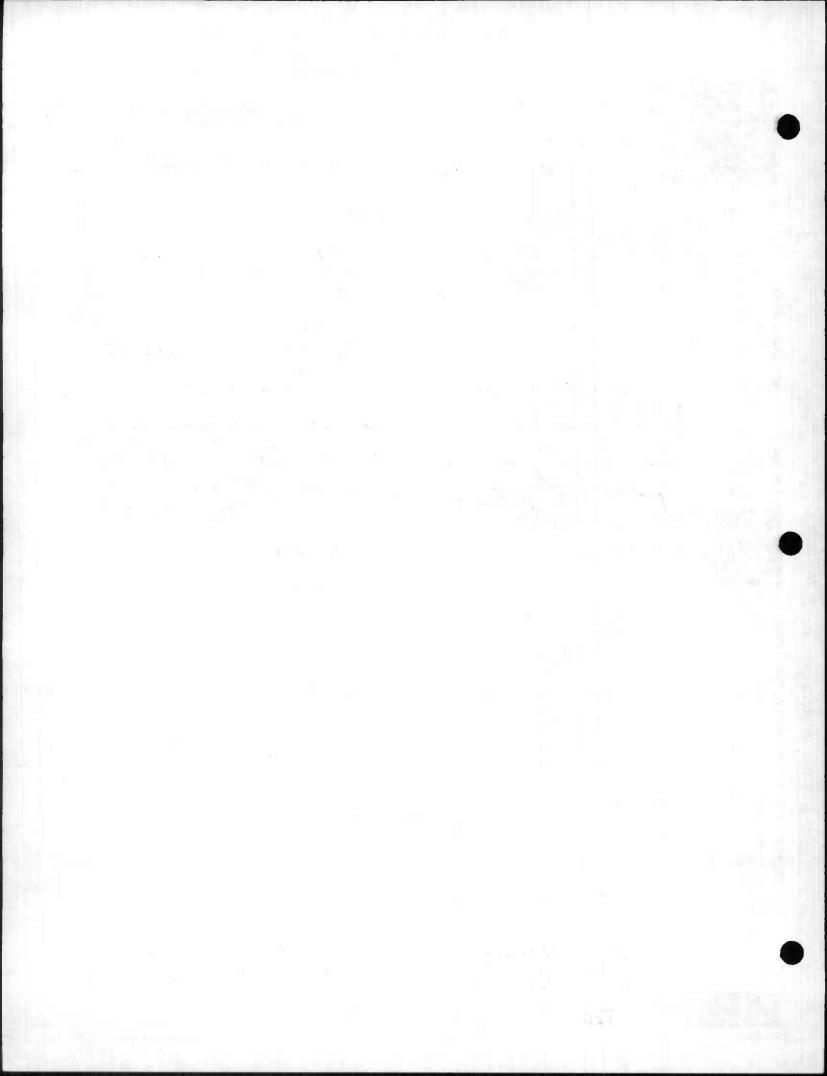
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Jacob Guy Ridenour, In

William B. Kerns MD maryland 31. Date filed (Month, Day, Year) 32. Registrate Signature

Julia Davidson Randelle

Registrar

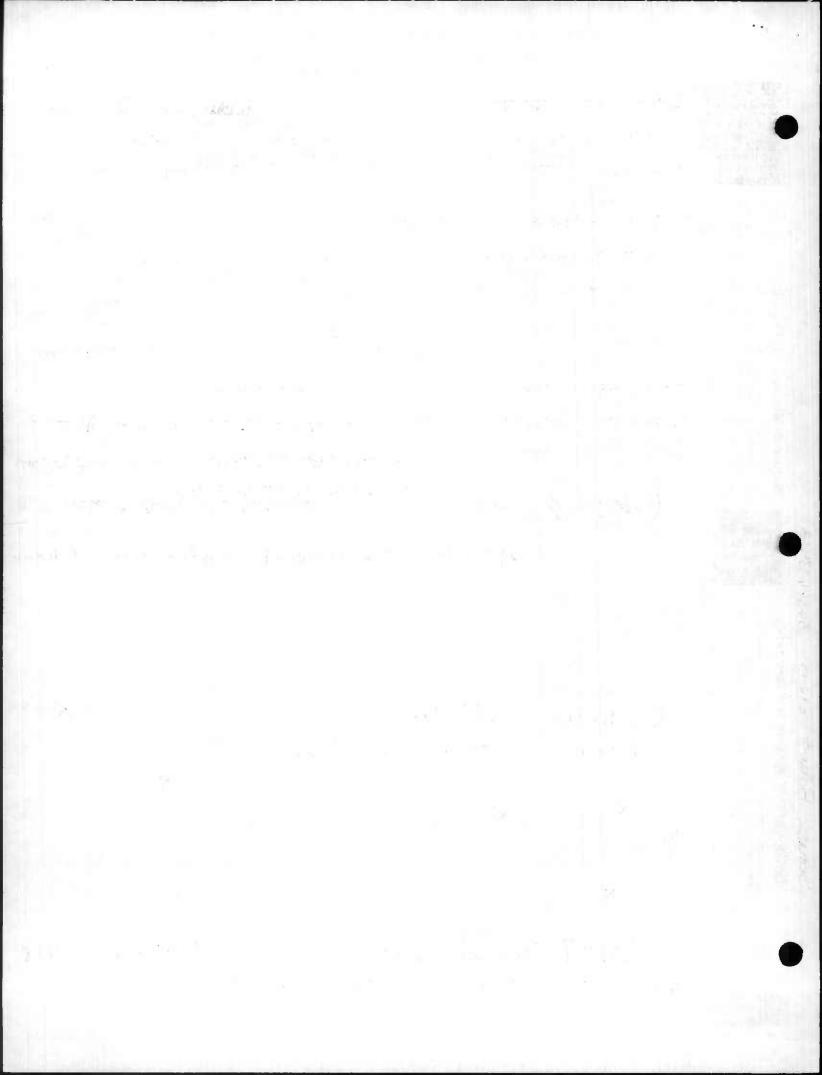


State of Maryland / Department of Health and Mental Hygiene

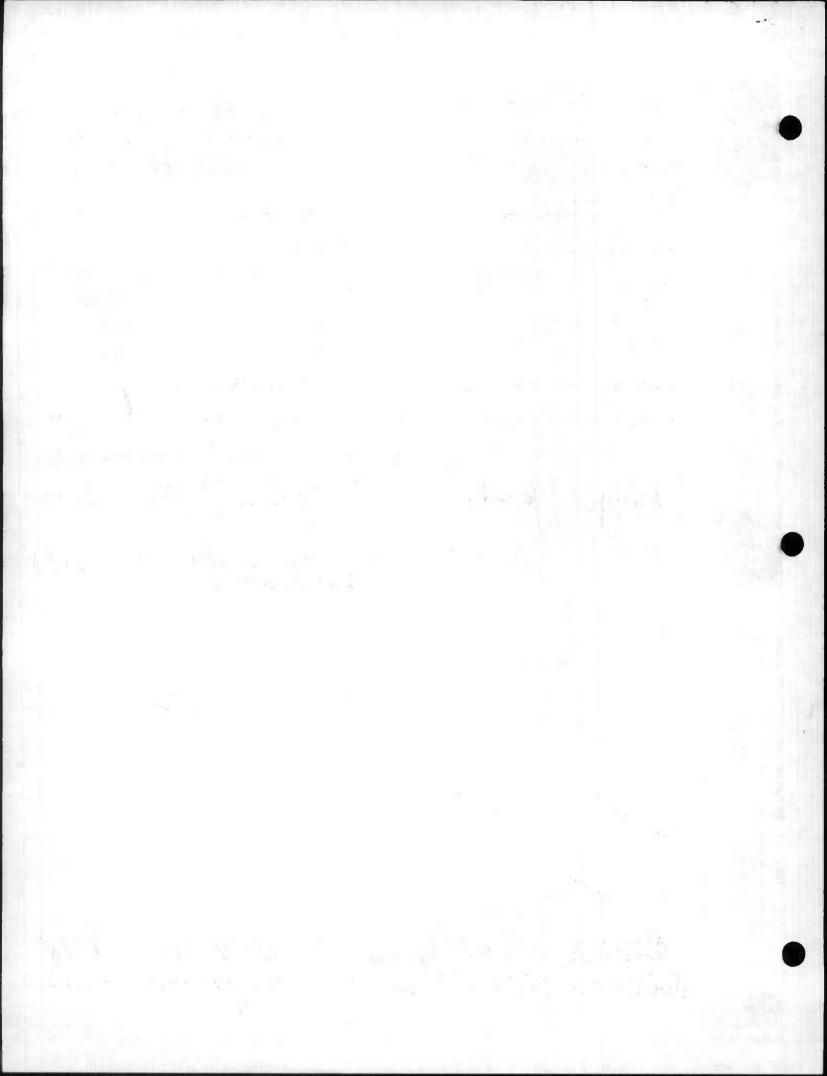
Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** ROBERT ELVIN SETTITES. 0902 tebbary 22 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Data of Birth
Mache | Days | Hours | Min. | (Month, Day, 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days 1 M 2 □ F 220-18-1734 Yrs. Director June 6, 1926 Maryland Usual Rasidanca of Decadant the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be nothing at 1 Yas 2 No Director Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ŏ filed within 72 hours eftar death with or items 23a 22419 Old Georgetown Road U.S.A. Funeral 21783 12. Was Decadant Evar in U,S. Armad Forcas? Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Naver Marriad 2 Married Maryland 21215-0020 1 ☐ Yas 2 ☒ No by Specify: 3 Widowed 4 Divorced "natural". White Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry than . Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filled will Depertment of Health end Mental Hygien Important: if item 27 is marked other thy any Injury or other traumatic event, the once. Custodian Board of Education 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middle, Maldan Sumama) Be James Duskin Settles Myrtis Lawson 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) V. Josephine Settles/Wife 22419 Old Georgetown Rd. Smithsburg, Maryland 21783 Baltimore, 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Method of Disposition 20c, Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park Feb. 25,1998 Hagerstown, Maryland 21. Signature of Funaral Sarvica Licansas 22. Nama and Addrass of Facility Douglas A. Fiery Funeral Home wucla 1331 Eastern Blvd. N. Hagerstown, Md. 23a. Pan I. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock or heart fellure. List only one cause on each line. Approximata Interval Batween Onset and Death Physician /Medical Immediata Cause (Final yocardial Inforetion hour disaasa or condition rasulting in death) Examiner attending physician and for use as the bunal-trensit that the death certificate be executed Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Disease or Injury that Initiated avants rasulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Dua to (or as a consequanca of): signed by the atte Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director; After this cardificata has been signs. 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? 1 Yas 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Yas 2 XV Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 2 ER/Outpatiant 3 DOA Certification: Mennar of Daeth 28b. Tima of 28c. Injury et Work? 28d. Dascribe how Injury occurred Natural 2 Accident 5 Pending invastigation 1 ☐ Yas 2 ☐ No illed in by the 3 Sulcida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Thomleida edicai Cardifying Physician: To tha bast of my knowledge, death occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 29a. Cartifian y Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and piece, and due to the basts of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Yaar) Ma 30. Name and eddress of person who completed cause of death (Itam 23a) (Type, Print) Dr. Albert Lai 370 Mill Street Hagerstown, Maryland 31. Data filad (Month, Day, Yaar) 32. Ragistrar's Signature State Julia Davidson Registrar

30386334



					Certific	ate of	Death		Reg. No.	S U	1368		
Physician		1. Decedant's Nama (First, Middla, L.			100			2. Date of Dec	eth Day	Yaar	3. Tima of Death		
/Medical	ı .	KENNETH RAYMOND		I				Feb	22/	998	10:10p.m		
Examine	r	4e. Facility Nama (If not institution, gi Washington County					4b. City, Town, or Hager				ngton		
uneral		5. Social Sacurity Number 6.	-	(In yrs. last birti 25 y	hday) If Ur Mont	ndar 1 Yaar ths Days	if Undar 24 Hrs Hours Min.	8. Data of Birt		9. Birthple	ace (Steta or Foraign		
rector	t	Usual Rasidanca of Decedant	J.						-		4		
whow I		10a. State 10b. County		10c. City, Town	or Location					10	od. Insida City Limits		
Part of Car	200		nington				Hagerst	own			1 X Yas 2 No		
r teme 23a or 28a-f show sper must be notified at Finansi Director	Tal Dir	10e. Straat and Number 1380 Marshall St	reet		10f.	. Zip Coda	21740		10g. Citizan of What Country? USA				
or Reme	2	11. Marital Status 1 ☑ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dacedant Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates:			acedant of h specify Cub s 2 No	dispanic Origin? (S an, Maxican, Puari Specify:	pacify Yas or No- to Rican, etc.)	14. Rac Blac Specify	a - Amarica ck, Whita, a			
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B .	Ď	Kenneth Raymond						ma (First, Middia, Mele Eve		ma)			
traumatic TO	-	19a. Informant's Name/Ralationship			Mailing Add	race (Streat	and Number or Ru			State Zin	Code)		
z7 ls		Kenneth Raymond					Acres,		-				
E of		20a, Mathod of Disposition		20b. Place of		(Nama of		Data	20c. Location -				
ŏ		1 Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Speci			Haven			Feb. 25	Hagers	town,	Maryland		
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any i	1	> Kelly / p	Sound	W						Marsi	land 21742		
by the attending physician and estached for use as the burlat-transit and Physician/Medical Examiner		disaasa or condition rasulting in death) Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or injury that initiated avants resulting in death) Last	b		e consequence of: a consequence of: a consequence of:) weeks		
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ed for		Part II. Other significant conditions	ontributing to death but	not resulting in	the underlyin	ng cause giv	ven in Part I.	23b. Did t	obacco use co	nteroute to	the cause of death?		
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director, page		25. Was case referred to redical examiner?					26. Place of Dea	ath (Check only o	ne)	10.75			
al dire	2	1 Yes 2 No	Hospital: 1 (a Impatient	2□ER/Out	patient 3	DOA OH	er: 4□ Nursing H	lome 5 ☐ Resid	lence 6 Doth	er (Specify)	,		
fune		27. Manney Death 1 □ Natural 5 □ Pending 2 □ Accident investigatio		Year) 28b. Tr	me of jury M	28c. Injur Wor	yat k? Yes 2□No	28d. Describe how injury occurred □ No					
To the Funeral Director: Affert completely filled in by the funeral Medical Certification:		3 Suicide 6 Gould not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Flural Route Number, City or Town, State)				
To the Funeral Director: completely filled in by the Medical Certifical	29a. Cartifiar (Check only one) 10 Cortifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.							, and dua to tha d irrad at tha tima,	cause(s) and me data and placa,	annar as sta and dua to	ited. the causa(s)		
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		Robert Brull	1459 1	POTOV	nac	AU	2. NO	rgers	town	2	1742		
State	1	31. Data filad (Month, Dey, Yaar)	32. Aegistrati	s Signature	-			V	(



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 2008 Ethel Marie Stotler 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown, Washington If Under 1 Yaar | If Undar 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Aga (In yrs. last birthdey) 8. Data of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) 1□м 2√х Months 214-28-5652 67 Yrs. March 18,1930 MD Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington Williamsport 1 ☐ Yes 3 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 12308 Cedar Ridge Rd. 21795 U.S.A. 12. Wes Decedent Ever In U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, atc.) Race - American Indian, Black, White, etc. I □ Yas 2 □ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) residence Homemaker 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Malden Sumeme) Louise R. Shaw Raymond Willard Hart 19a. Informent's Name/Reletionship (Typa, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ralph Stotler 12308 Cedar Ridge Rd. Williamsport, MD 20b. Plece of Disposition (Neme of cemetery, cramatory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 Burial 2 □ Cremetlon 3 □ Ramoval from State 4 □ Donetion 5 □ Other (Specify) Cedar Lawn Park Feb. 25, 1998 Hagerstown, MD 21. Signeture of Funaral Service Licensea 22. Name end Address of Fecility Thompson Funeral Home, Inc. 23a. Part 1. Entar tha disa e, or controllications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, MD. 21722 Approximate shock, or heer feilure. List only one cause on each lina. Immediata Causa (Finel disease or condition resulting in deeth) neumonis Due to (or es e consequence of) Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 9 es 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of ceuse of death?

Physiclan /Medical Examiner

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-1 show traumatic event, the Medical Examinar must be notified at

with the Meryland

permit. Pages 1 and 2 should be filed within 72 hours efter death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "--- any highly or other traumests.

end ettending physician the ate hes been signed by the ettending p page 2 should be deteched for use es funeral director,

Attanding Physician: The law requires thet the death certificate be executed

certificate

this

After

To the Hosp within 24 hor To the Fune completely fi

ö Hospital 24 hours

Physician/Medical Examiner Completed by Be Certification: To n 24 hours efter death.

Ne Funeral Director: Al pletely filled in by the fu

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initialed events resulting in deeth) Lest Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yas 2 No 25. Was case referred to medical 26. Piece of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 1 Maturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Sulcida 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Medical

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Routa Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted. 2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stelled.

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

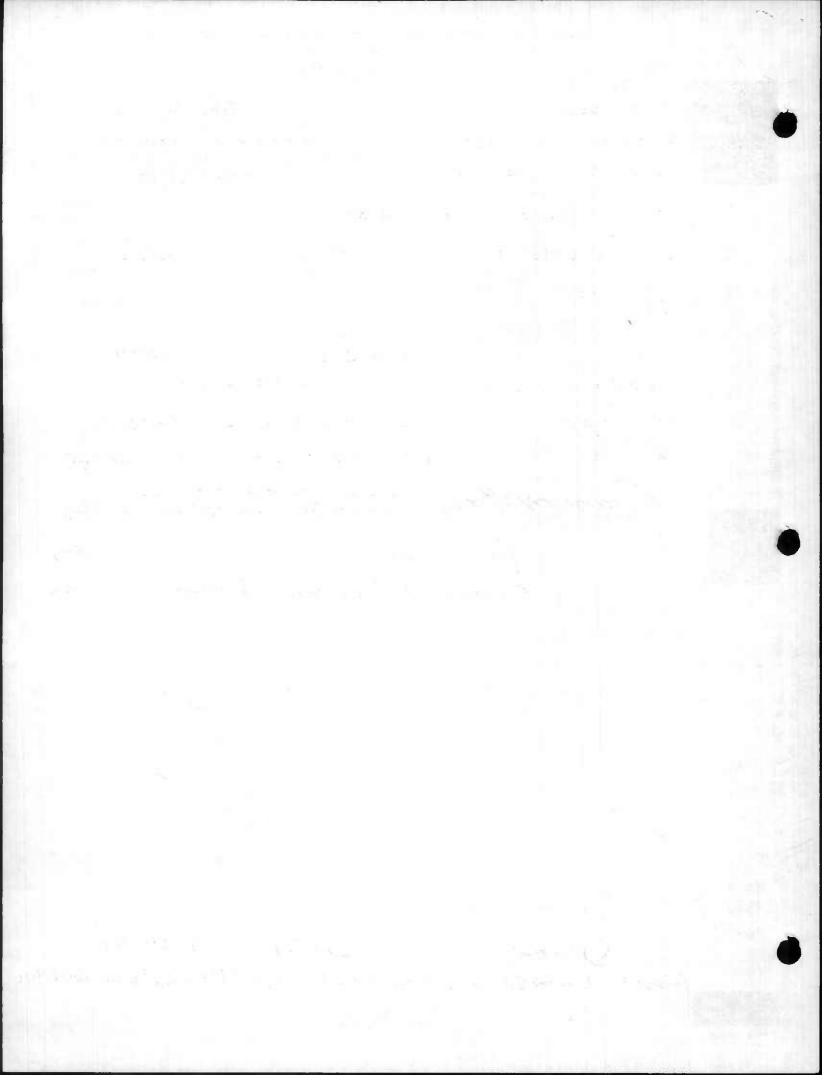
slues

BOUL 31. Date filed (Month, Day, Yeer)

MD-12821-OAK HILL AVE. HAGERSTOWN MOZIAN WATER 32. Registrar's Signature

Registrar

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? EVAS HOWE Expired 2-22-98 @ 805pm Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Deeth **Physician** Month 8:05 PM 22 **EVA** LORENA SHOWE Leb /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner AVALON MANOR HEALTH CARE CENTER HAGERSTOWN WASHINGTON 5. Social Security Number 8. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 8. Dete of Birth (Month, Dey, Year) 1□ M 2⊠ F Months Deys Hours Yrs. Director 217-18-7143 JUNE 10, 1916 MARYLAND Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location r than "natural", or itsms 23s or 28s-f show the Medical Examinar invest be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MARYLAND WASHINGTON BOONSBORO 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8031A OLD NATIONAL PIKE 21713 Funeral U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 ☐ Yes 2 No Specify: Be Completed by Specify 3 Widowed 4 □ Divorced WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiena. Important: If Itam 27 is marked other than "na any injury or other traumatic event, the Medagonce. Elementery/Secondary (0-12) Coilege (1-4or 5+) INSPECTOR CLOTHING MANUFACTURE Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) NIMROD A. JONES ANNA A. HAUSE 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) NANCY L. SMITH/DAUGHTER 8339 DEERFIELD LANE, HANCOCK, MARYLAND 21750 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) BOONSBORO CEMETERY 2/25/98 BOONSBORO, MARYLAND 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be asscuted burial-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest P.O. Box 68760, Physician/Medical the Due to (or es a consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Vascular Records, þ ata has been signe page 2 should be Be Completed 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Heart Facture Vital certificata 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitai: 1 ☐ inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 1 Yes 2 No Certification: To to this 27. Manner of Deeth 1 ☑ Naturel 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? Aftar Division or Attending 5 Pending Investigation 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suiclde In by t 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 T Homleide Hospital 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner steted.

To the Hosp within 24 hor To the Fune completely fi

Medical

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Registrar

29a. Certifier

(Check only one)

ZMFMR 31. Dete filed (Month, Dey, Year)

30. Neme end eddress of person who completed ceuse of deeth (item 23e) (Type, Print)

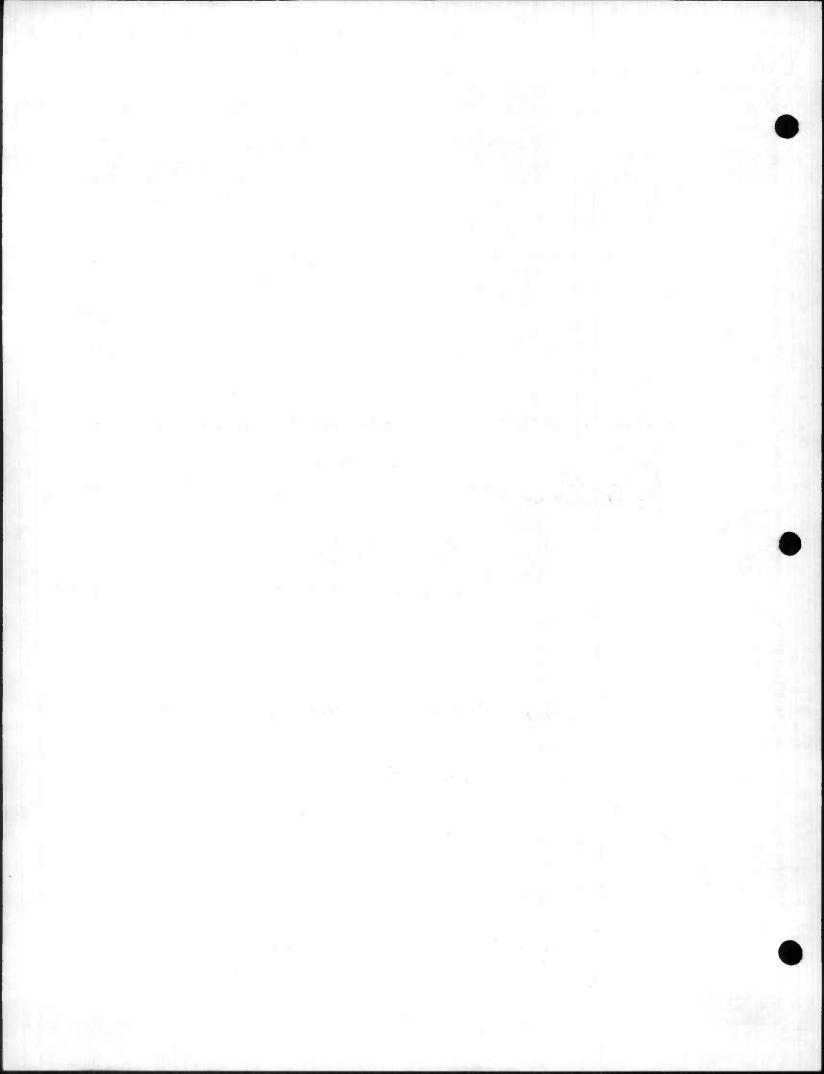
29b. Signeture end title of certifier

MMIK 40 20311 32. Registrer's Signature Julia Davidson-Randelle

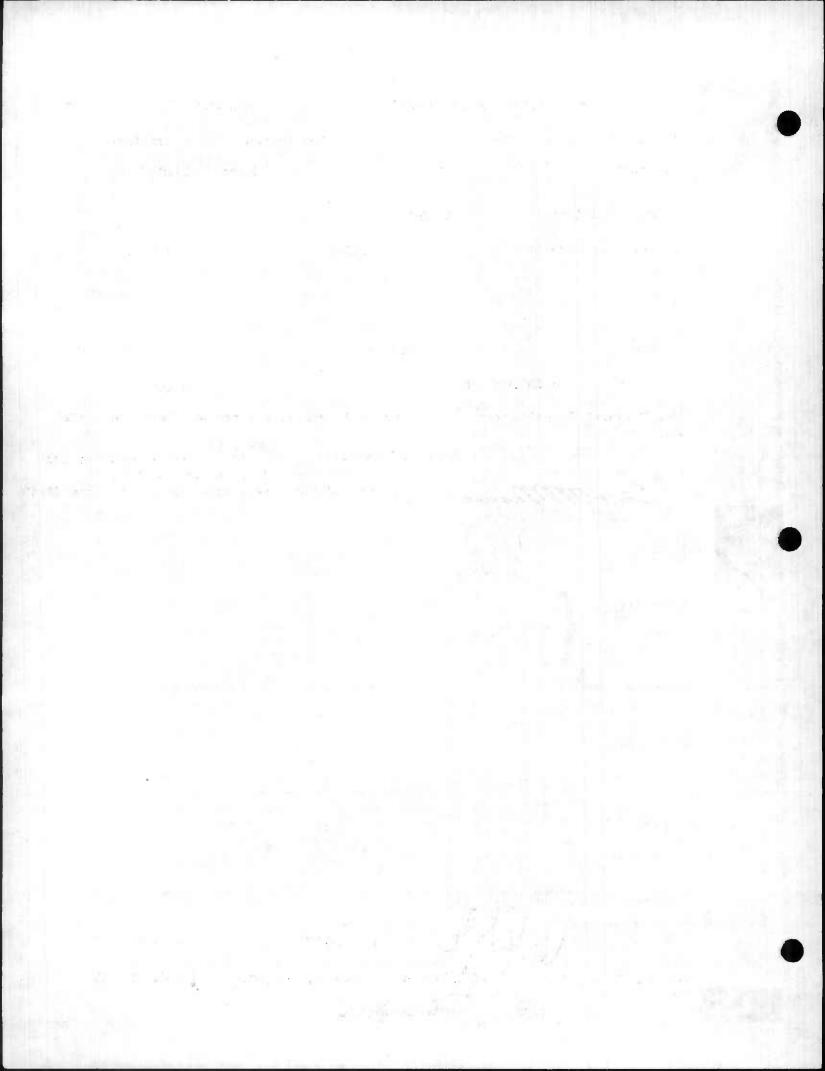
29c. License number

144996

29d. Date signed (Month, Dey, Year)



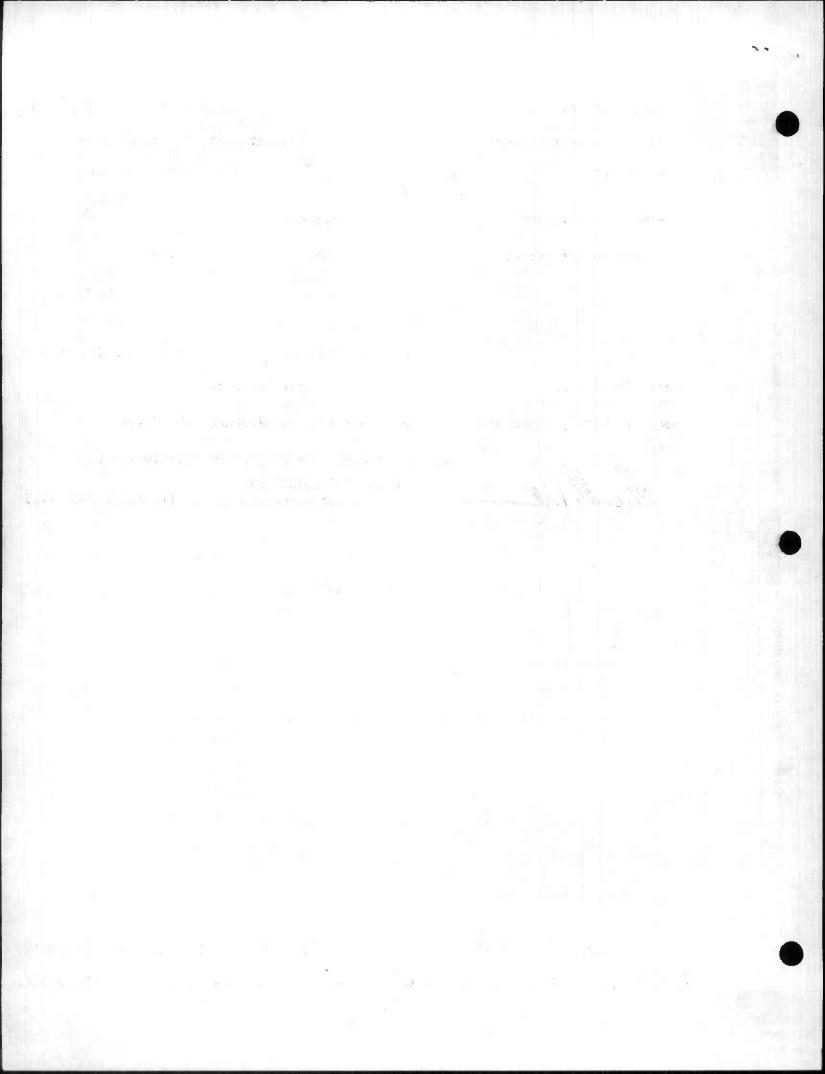
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a-f s	ctor	Maryland Washing	ton	Hager	stow	n				XXYas 2[
23a or 28	Funeral Director	10e.Street and Number 11 West Baltimore	Street			10f. Zip Coda 21746)	11	What Count	iry?				
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natu natu	etec	15. Decedant's E (Specify only highast gr	ducation ada complatad)	16	a. Daceda	int's Usual Occu	pation	working	6b. Kind of B	usinass/Ind	ustry			
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Ment	To		hlotterbec					Anna Knight						
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Department of H Important: If its any Injury or ott	1 ■ Burial 2 □ Cramation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Specify) Feb. Rose Hill Cemetery 1998									b. 25, Hagerstown, Marylar				
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ettending physician and for use es the burial-transit	n/Medical	Sequantially list conditions, if eny, leading to immadiate cause. Entar Undartying Causa (Disaasa or injury that initiated evants rasulting in daath) Last	d	tion o:	F COPD			H	ours					
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	30. Nama and address of person who complated causa of dea n (Itam 23a) (Type, Print)													
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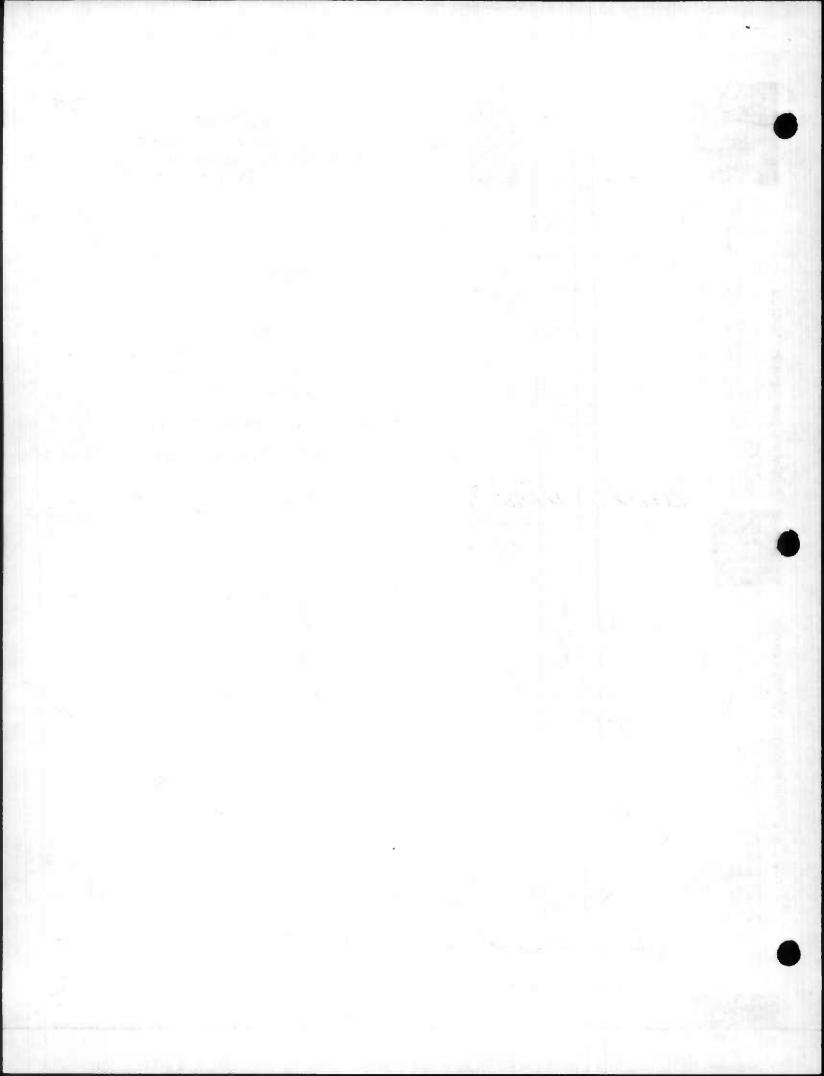
Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Dete of Daath **Physician** Month February Francis Albert Shaw 1998 Am /Medical 4e. Fecility Neme (If not Institution, giva street end number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner 201 East Sunset Avenue Washington Williamsport 5. Sociel Sacurity Number 6. Sax XXM 2□ F If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Sept. 2, 1914 Birthpiace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Director 215-07-4241 83 Yrs. Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yes 2 No Director Maryland Washington Williamsport 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ŏ Items 23a 201 East Sunset Avenue 21795 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: WW | | Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. Fages 1 and 2 should be filed within 72 hours effer inent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White by 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Machine Operator Truck Manufacturer 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Frank Albert Shaw Ella Mae Byrum 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Important: If Nem 27 is any injury or other tra-once. JoAnn Y. Everly / Daughter P.O. Box 1999 Martinsburg, WV 20b. Place of Disposition (Neme of cematary, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Ramoval from State Other (5 Greenlawn Memorial Park 2-24-98 Williamsport, MD eral Serv 22 Name and Address of Fecility
USBorne Funeral Home 425 S. Conococheague St. Williamsport, MD 21795 complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, only one cause on each line. Approximate Intervel Between Onsat and Deeth Physician /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) **Examiner** Examiner years leronc ettending physician and for use es the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of) Box 68760. Physician/Medical Due to (or es e consequence of): P.O. 1 signed by the e Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown Records. þ page 2 should Completed 24e. Wes en eutopsy performad? 24b. Were eutopsy findings evelleble prior to complation of ceusa of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 1 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA funerai 27. Menner of Deeth Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation s efter death. 1 Yes 2 No the 2 Accident 6 Could not be determined 3 Suicida 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicide within 24 hours To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta and place, end dua to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29a. Certifier Medical completely (Check only one) the 29b. Signetura and titla of certifian 29c. License number 29d. Deta signed (Month, Dey, Yeer) 30. Nama and addrass of person who completed ceuse of deeth (Item 23a) (Type, Print) mt. Aetna Rd. Hagerstown, mD 21740 32 Registrar's Signature 31. Date filed (Month, Dey, Year) State uha Davidson 23 Registrar

DHMH 16 Rev 6/95



					Certif	ficate of	Death		Reg. No.	0/3	373	
Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Data of De Month	ath Day	Voor	Time of Death	
/Medic		Nannie Cardwe		h				Februar	rv 20.	1	AM	
Examin	er	4a. Facility Name (If not institution, give	and the same of th				4b. City, Town, or	Location of Death				
		240 Prospect A				Under 1 Year	Hagers			ington		
Funeral Director		5. Social Security Number 6. Se 229–14–6533 Usual Residence of Decedent	x 7. Age 3 M 2□ F 78		onths Days	9. Date of Bir (Month, Da		9. Birthplaca (Country) Virgini	Stata or Foreign .a			
ylend M M		10a. State 10b. County		10c. City, To	own or Locati	ion				10d. Inside City Lim		
Mar Mar	tor	Maryland Washing	ton	Hager	stown					124	Yes 2 No	
ter death with the Marylen Herns 23a or 28a-f show Instrument be notified at	al Director	10e. Street and Number 240 Prospect Aven	ue			10f. Zip Code 21	740		10g. Citizen of USA			
urs af	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ② N If Yes, Give Yaar or Datas:			Dacedant of es, specify Cul	Hispantc Origin? (S ban, Mexican, Puar Specify:	Specify Yes or No to Rican, atc.)		14. Race - American Indian, Black, White, atc. Specify: Black		
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should be ind Mental marked o umatic eve	10	John Cardwel					Nannie		mes			
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80 = 3		t Burial 2 □ Cramation 3 □ F 4 □ Donation 5 □ Other (Specify)		ceme	tery, crameto	Ceme te	ery	2/24/98				
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tificete be ig physicis es the bu	Physician/Medical Examiner	Immediata Cause (Final disease or condition resulting in death) a. Arrhythmia Due to (or as a consequence of): Auterioscleratic /fearl Disease Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or thirty indicated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of):										
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2 10 73	2	1 ☐ Yes 2⊠ No	lospital: 1 Inpatier	t 2 ER/	Outpatient	3□ DOA O		lome 5 Resid	dence 6 🗆 Oth	nar (Specify)		
Attending Physic death. actor: After this by the funeral c	Certification:	27. Mannar of Death Naturat Accident To Panding invastigation	28a. Date of Injury (Month, Day	o. Time of Injury	28d. Describe I	d. Describe how injury occurred						
fre fre	Certific	3 ☐ Sutcide 6 ☐ Could not be 4 ☐ Homicida determined	28e. Place of triju building, etc.		28t. Location (: City or Tox		ber or Rural Roul	le Number,				
To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edical	29a. Cartifiar (Check only one) 1 Certifying Physical Exami	ner: On the best of and manner state	ime, date and place opinton, death occu	a, and due to the urred at tha tima,	cause(s) and m data and place,	anner as stated. and due to tha o	ause(s)				
With Total	2	29b. Signature and the of certifier 29c. Licanse number D 11133							29d. Data signed Feb 2			
		30. Name and address of person who co	protested cause of de	ath (Item 23a	a) (Type, Prin	N) Lical Ca	my w Rd	Hageria	our M	D 211	42	
Stat	te	31. Data filed (Month, Day, Yaar)	32. Registr	The same of	1. %	2.00		10.00		211		



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Month **FRANCES** ELNORA SHOEMAKER Ph /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs. Months Devs Hours Min. 5. Social Security Number 8. Date of Birth (Month, Dey, Yeer) 9. Birthplace (State or Foreign Country) AUG 29, 1923 WAYNESBORO, PA 7. Age (In yrs. lest birthday) **Funerai** Deys 1 M 2 KF Yrs Director 200-12-5732 74 Usuel Residence of Decedant Pagas 1 and 2 should be filed within 72 hours after death with the Meryland nant of Haaith and Meniel Hygiene. Int: If item 27 is marked other than "naturel", or items 23s or 28s-f show 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director WASHINGTON HAGERSTOWN 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? "naturel", or items 23s or 12 S WALNUT ST 21740 USA by Funeral 11. Maritel Status 12. Was Decedent Ever in U,S Armed Forcas? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) College (1-4or 5+) SECRETARY ARMY DEPOT 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Be JOSEPH STEPHEY OTTIE V. FITZ 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Lizetta M. Schrock/ Daughter P. O. Box 713 Blue Ridge Summit ortant: If item 27 Injury or other tr PA 17214 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 X Removel from Stata Green HIll Cemetery 2/25 Waynesboro PA 17268 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Grove Funeral Home, Inc. 21. Signature of Funerel Service Licenses 50 S Broad ST M. Bowersot Waynesboro PA Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errast, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner The law requires that the death cartificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Lest Due to (or es e consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□Yes 200 1 ☐ Yes 2 ☐ No this cartificata of Vital or Attending Physician: 25. Was case referred to m 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 □Other (Specify) ↑ Yes 20 Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Aftar Division Matural 5 Pending 1 Yes 2 No investigation 2 Accident oftar death 3 Suicide 6 ☐ Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

f Certifying Physician: To tha bast of my knowledga, daeth occurred et the time, date end plece, end dua to the ceusa(s) and mennar es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) FeB. 21 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State Registrar

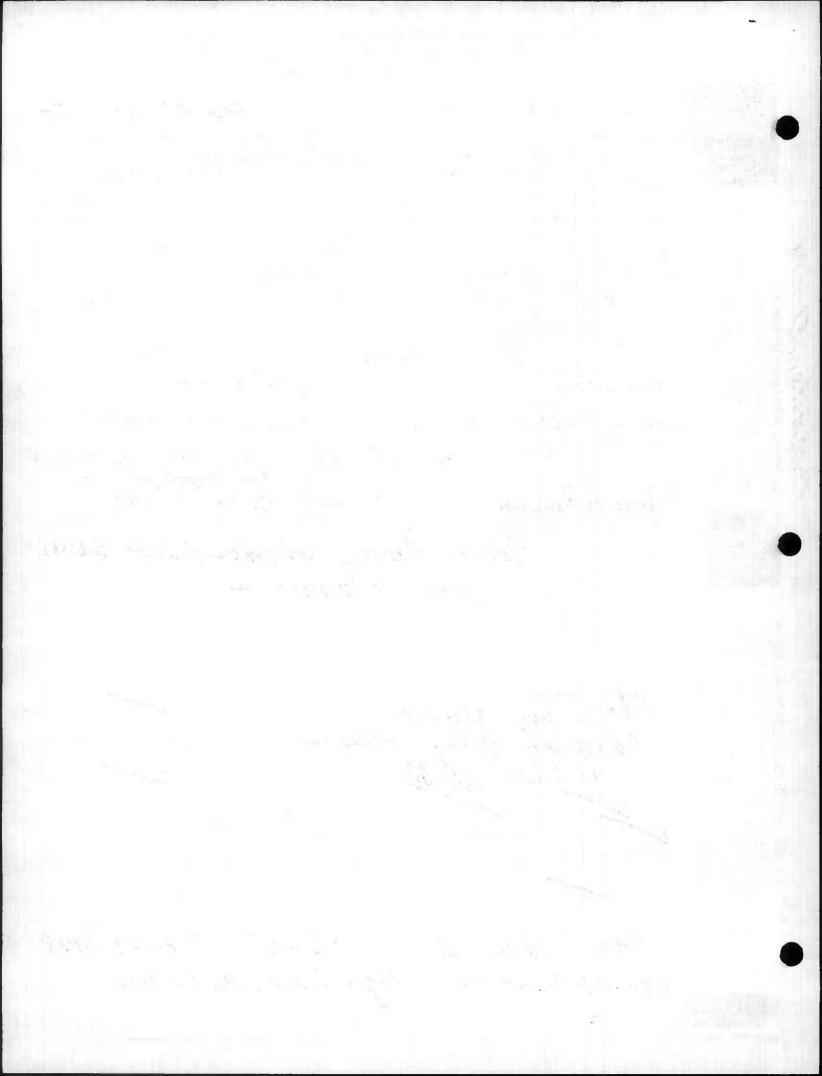
To the Hospital or within 24 hours eft To the Funeral Di complately filled in

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Dey, Year)

Medicai



G. Sumerlad nirian

1. Decedent's Nama (First Middle Lest)

5. Sociel Sacurity Number

213-03-4950

10a Stata

Usual Rasidenca of Decedant

4e. Facility Nama (If not institution, giva street and number)

10b. County

Miriam Glendora Somerlade

Washington County Hospital

1□M 2以F

7. Age (In yrs. last birthdey)

78

Physician

/Medical

Examiner

Funerai

Director

Division of Vital Records, P.O. Box 68760

10c. City, Town or Location 10d. insida City Limits 28a-f show Washington 1 Yes 2 No Director Hagerstown 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? ò 13448 Clopper Rd. 21742 U.S.A. 238 Funeral Hems Wes Dacedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Reca - Amaricen Indian, Bleck, Whita, atc. 11. Marital Status Armed Forces 2 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 ☐ Never Married 2 ☐ Married natursi', or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No White þ Specify: 3 Widowad 4 □ Divorced Completed 15. Dacedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Heelih end Mental Hyglene. Important: If Item 27 is marked other than "tany Injury or other traumatic event, it is Med Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home. 12 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumama) Be Walter Calvin Rowe G. Murtle Brunner 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Routa Number, City or Town, State, Zip Code) David W. Somerlade (Son) 13448 Clopper Rd. Hagerstown, Md. 21742 20a. Mathod of Disposition 20b. Placa of Disposition (Nema of camatary, crametory or other placa) 20c. Location - City or Town, Stata 1998 1 Burnal 2 X ramation 3 Bernoval from Stata Feb. 17. Smithsburg Crematory Smithsburg. Md. 1. Signature of Euperal Service Lin 22. Nama end Addrass of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. **Physician** /Medical Immediata Cause (Final disaasa or condition resulting in daath) lulateral 6days lunon ca Examiner Dua to (or as a consequence of): Examiner OUSclsician end buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laeding to immadiata ceusa. Enter Undarfying Cause (Disaasa or Injury that initiated evants resulting in daath) Last Due to (or es e consaguance of): physician es the buriel Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown hone by 24b. Wera autopsy findings eveileble prior to complation of ceuse of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas or Attending Physician: 25. Wes casa rafarred to medical axaminar? 26. Place of Deeth (Check only ona) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA this 27. Menner of Daath 28b. Tima of Injury 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28c. Injury at Work? N 1 Yas 2 No After 5 Panding invastigation 1 Natural
2 Accident within 24 hours efter death.

To the Funeral Director: A completely filled in by the fi NIA WIA WIA 6 Could not be detarmined 3 ☐ Suicide 28a. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Certifying Physician: To the best of my knowledga, daath occurred et the tima, data and place, and dua to the causa(s) and mannar as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the causa(s) end mannar stated. Hospital 29a. Cartifier (Check only one) 29b. Signetura end titla of cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 2-16.98 028365 30. Nama and address of parson who completed cause of gaath (Item 23a) (Type, Print) JSHAPI 368 HUICL STREET HACIENSTOWN MD 21740. 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura State Julia Davidson FEB 1 Registrar **DHMH 16 Rev 6/95**

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Data of Death

745

9. Birthplaca (State or Foreign

Maryland

Month

4b. City, Town, or Location of Daath

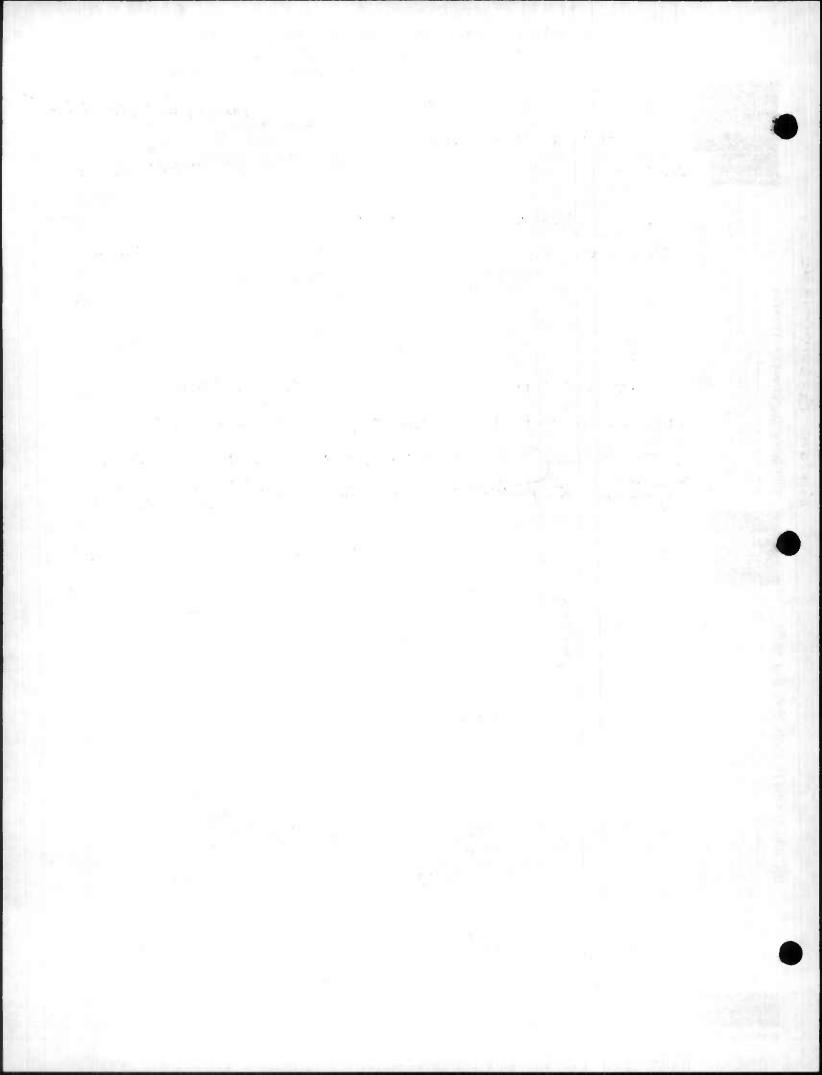
Hagerstown

If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. June 1977, 19

tebruary

4c. County of Deeth

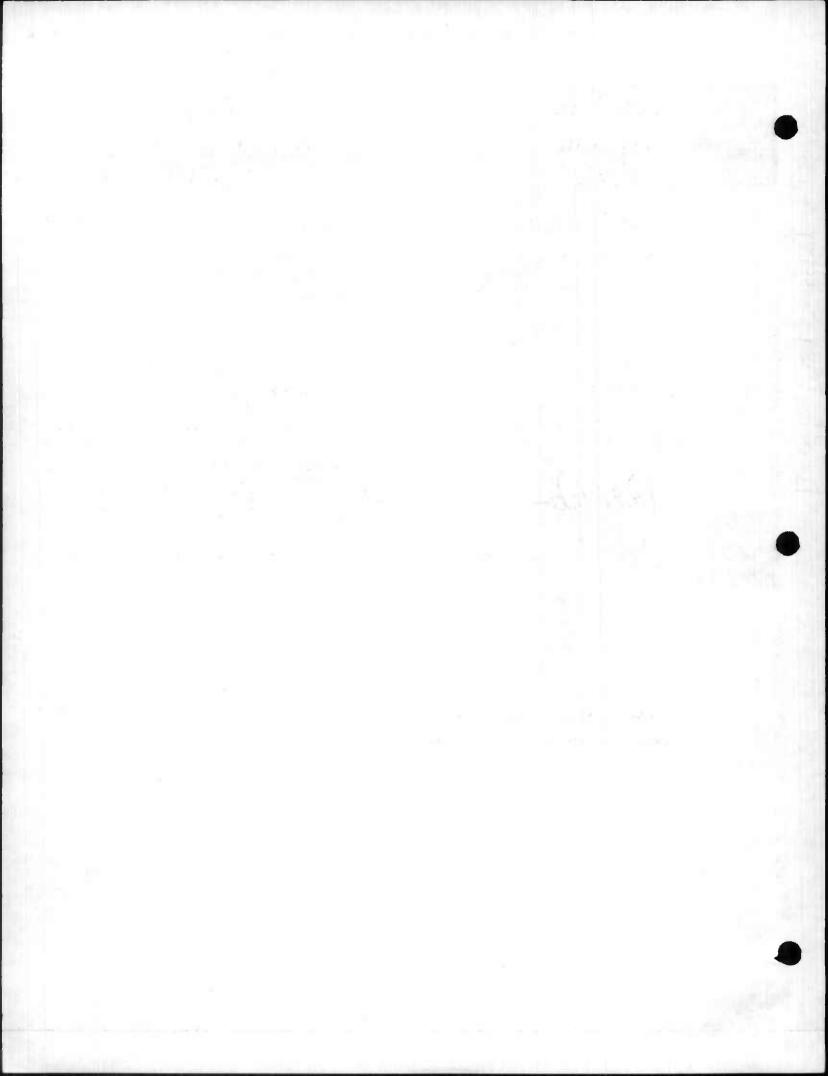
Washington



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 18 17376

		1 Doordook Nove (First Middle)			Certific		Death		Reg. No.		
Physicia	n	Decedent's Neme (First, Middle, L DECETE A MADE		7.7				2. Dete of D	Dey	Xeer 3	Time of Deeth
/Medica		LORETTA MAR 4e. Flacility Name (If not institution, g					4b. City, Town, o	rebru(940	7133.
Examine	er		11	and Villa	ne		D	~ m . I	1 1	Shington	
Funeral		5. Sociel Security Number	Sex 7. A	ige (In yra. last t		der 1 Year			lirth	The second of the second	(Stete or Foreign
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show show stat		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, To	wn or Location					10d.	Inside City Limits
in the Maryla or 28a-f sho e notified at	Director	MARYLAND WASHI	NGTON			BOONS	BORO				1 ☐ Yes 2 ☒ No
5 0 3		10e. Street end Number			10f.	Zip Code			10g. Citizen of	Whet Country?	
n 23s must	era	8507 MAPLEVILLE 11. Maritel Status	ROAD 12. Was Deceden	t Ever In II S	13 Was De	ondent of	21713			U.S.A.	ndian
n 0 m	by Funeral	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Detes	i? INo		specify Cut	Hispenic Origin? (pen, Mexican, Pue Specify:	rto Ricen, etc.)	Ble	ck, White, etc.	ndien,
natural, natural,		15. Decedent's I			a. Decedent's L	Isuel Occu	netion		16b. Kind of B	WHI	
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D 10 4 40	0	5	College (1-40)	34)	HOM	EMAKI	ER		OW	N HOME	
世工芸士	Be	17. Fether's Name (First, Middle, Las	t)				18. Mother's Na	ame (First, Middl	e, Meiden Sumer	ne)	
	ှ	THOMAS IRWIN					MARY I				
0. 中華 書		19a. Informent's Neme/Relationship					t end Number or F				. = 1.0
t of Health If Item 27 or other tr		THOMAS W. SWEENE 20a. Method of Disposition	Y/SUN	20b. Plece	of Disposition (Neme of	RDSTOWN I	PIKE, BO	ONSBORO,		1/13 Stete
Pages nent of net: If it ny or o		1 ⊠ Burlel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec		9	tery, cremetory		·	h /10 /00			
교 본론은	-	21. Signe are o Funerel Service Live	**	BOOL	NSBORO (22. Name		ERY ess of Fecility		BOONSBO		
Depa Impo any is		100m/16	Paul I	M. Dean	BAST 1	FUNER	AL HOME		ld Nation		
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/Medical Examiner		Immediate Cause (Final disease or condition	M	electil	2 G	nui	am B	oth rou	ant		12
		resulting in deeth)	0.	Due to (or es	e consequence	of):					
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ficate be executed physician and as the burial-transit	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying		Due to (or es e	e consequence	of):					
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5 D 6 3		resulting In deeth) Last		Due to (or es e	consequence	и.				1	
Attending Physician: The law requires thet the death cert rideath. setor: After this certificate hes been signed by the attendin by the funeral director, page 2 should be detached for usa	Physician/M		d								
the a	SIC	Pert II. Other significent conditions	contributing to deeth	but not resulting	In the underlyin	g ceuse gi	ven in Pert I.	23b. Did	l tobacco use co	ntribute to the	cause of death?
ed by detac	5	Anterio relenta	2 Cardin	male	- Din	an,		10	Yes 2 No	3 Probabl	y 4 Onknown
signed id be de	d Dy	Arterio relevati	1675 1	0:40	00-11-	_		24e We	s en eutopsy	24h Were 6	autopsy findings
w require	Completed	Acres 1				٠			formed?	comple	ole prior to etion of cause
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hysician his certifi i director		exeminer?	Hospital:	ient 2 ER/C	Outnetient 3	DOA Ot	hor	eth (Check only	idence 6 Oth	er (Snecily)	
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ath. Ar: Aftar he funer	atio	1 Naturel 5 Pending 2 Accident investigation	n	by rear/	Injury M		Yes 2□No				
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urs el urs el illed i	2										
thin 24 hours the Funer ampletely fill	200	29a. Certifier 1 ☐ CertifyIng P (Check only one) 2 ☐ Medical Exa	nysician: To the best miner: On the basis of	of examinetion e	ge, deeth occurr and/or investiget	ed et the ti ion, in my	me, dete end pled opinion, deeth occ	e, end due to the curred at the time	e cause(s) end me , dete end plece,	enner es steted and due to the	d. ceuse(s)
To the Hospital or Attending Physician: The law within 24 hours effar death. To the Funeral Director: Affar this certificate has completely filled in by the funeral director, page 2	2	one) end menner steted. 29b. Signeture end title of certifier 29c. License number 29d.									, Year)
F 3 F 8		1200 D18017 Feb 16, 1998									
	-	30. Neme and eddress of person who		death (Item 23e)	(Type Print)		- ' '				
		person with	Completed Gagg Of		/ (17po, 1 mill)						
State	,	31. Dete filed (Month, Dey, Year)	32. Regist	Julia Davi			3				
Registrar	r	FEB 17	1998	gwia Davi	idson-Nam	Alle	1				
	_										

Lonetha Mary Sweeney



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Nerbert Noble 2246 /Medical 4a. Facility Nama (If not institution, giva street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Hospital Washington 5. Sociel Security Number County Hagerstown If Under 24 Hrs. 8. Dete of Bi Washing ton

9. Birthplebe (State or Foreign
ar)

Country) 6. Sex 1. → M 2 ☐ F If Undar 1 Year 8. Dete of Birth (Month, Dey, Year) SEP 25' 1 Aga (In yrs. lest birthday) **Funeral** Months Days Hours 181-38-7857 Yrs. Director 28, 1950 Lagerstain Mo Usuel Rasidence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits Yas 2□No Director Franklin Greencastle 10e Street and Number 10f. Zlp Coda 10g. Citizen of What Country? rel', or items 23a or Examiner namt be 17225 arliste St USA death by Funeral 12. Was Decedent Evar In U.S. Armed Forces? Race - Amarican Indien, Bleck, White, etc. 13. Was Dacedant of Hispenic Orlgln? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) filed within 72 hours after 1 Nos 2 Nos If Yes, Give Yeer or Detes: 1 Naver Married 2 Married Maryland 21215-0020 1 Yas 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced th end Mental Hygiena.
7 Is marked other than "naturitraumatic event, the Maxical" Completed 15. Decedent's Education (Specify only highest grada completed) 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Services 12 Shipping Clerk 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surnama) Be Peges 1 end 2 should be finent of Health end Mental I Erdman Herbert lildred eree 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) itsm 27 is Pa Shatzer-Wite Greencestle 19 NCarlisle St other t Baltimore, 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 SCrametion 3 Removel from Stata = 0 Depertment of Important: If any injury or Cumberland Valley Crem 2/18 4 ☐ Donetion 5 ☐ Other (Specify) Waynesboro 22. Name end Address of Fecility G tove 21. Signeture of Funerel Service Licensee Funera ! 23a. Per I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory en shorts, or heart failure. List only one cause on each line. Pa 17268 wayneshord Approximete Intervel Between Onsat and Deeth **Physician** /Medical Immediate Ceuse (Finel 300060 HYPERTENSIVE HEART disaasa or condition resulting in death) DISEMSE WITH VENTRICULAR Examiner Due to (or es a consequence of): PIBRILL ATION Sequentially list conditions, if eny, leading to Immadiete cause. Enter Undarlying Cause (Diseese or Injury that Initieted events resulting In deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequanca of): for use es Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Hritiknown AELLITUS, TORE II Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? director, paga 2 should RENAL FAILUNE, certificeta 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 1 Maturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No NONE 2 Accident To the Hospital or Attenwithin 24 hours after deet To the Funeral Director: 6 Could not be determined 3 Suicide 28a. Placa of Injury - At home, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homlcide 29e. Certifier (Check only one) 1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceusa(s) and manner as steted. Medical 2 Medical Examiner: On the basis of axaminetion end/or investigetion, in my opinion, deeth occurred at the time, dete and pleca, and due to the ceuse(s) end menner stated. completaly 29b. Signeture and title of certifier 29c, Licansa number 29d. Dete signed (Month, Dey, Year) 02-16-98 01040 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 18706 BHARY M. CRESTWOOD COHEN MD DRIVE, HA WERSTOWN, MZ 31. Deta filed (Month, Dey, Year) 32. Registrar's Signature

who Davidson-Randell

State

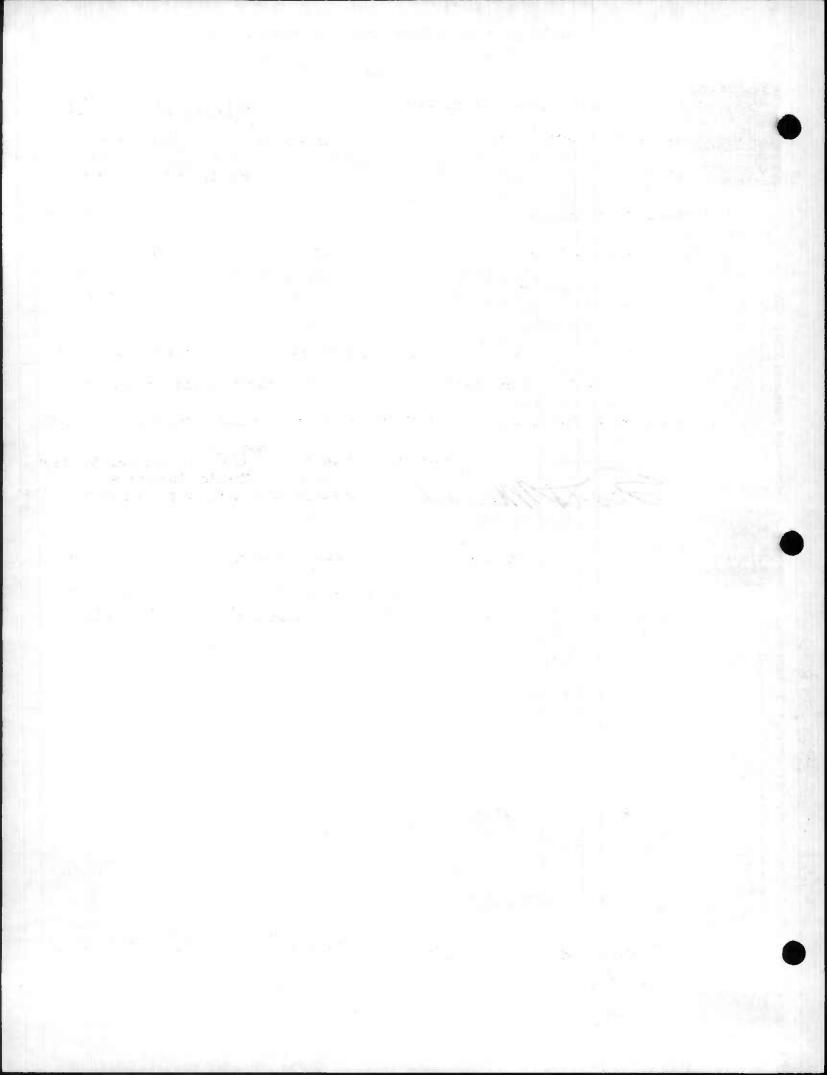
Registrar

FEB 1

State of Maryland / Department of Health and Mental Hygiene 98

						Cei	rtificate	e of	Death			Reg. No	0.		
1	Physic	ian	Decedent's Neme (First, Middle, Robert	_	STOTTLE	MYER					2. Date of De	eath Da		Yeer	3. Time of Death
	/Medi		4e. Fecility Neme (If not institution, o					_	4b. City. To	own, or Lo	repru	-	County	1998 · of Deeth	1800.
1	Exami	ner	Washington Coun		*				Hager				Washington		
	Funeral Director		5. Social Security Number 217–16–2316	Sex txCxM 2□ F	ge (In yrs. last I 70	birthday) Yrs.	If Under 1 Months		If Under	24 Hrs. Min.	(Month, Dey, Year)			9. Birthpl Count Mary	ace (State or Foreign try) land
	pue *		Usual Residenca of Decedent 10a. Stete 10b. County	10c, City, To	wn or Lo	cation								Od. Inside City Limits	
	se-f sho	Director	Maryland Washi	ngton			amspo	rt							1 Yes 28 No
	23a or 2	ral Dire	16725 Buford	Drive	10f. Zip Coc				1795			10g. Citizen of What Country? $U \bullet S \bullet A \bullet$			
0200	filed within 72 hours efter death with the Maryland Hygiene. The Train 1998 or 284-4 show ent, the Medical Examiner must be notified at	by Funeral	11. Maritei Status 1 □ Never Married 2 ☑ Marriec 3 □ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	7 INO 1945		Was Decede f Yes, speci 1 ☐ Yes 2				ecify Yes or No Ricen, etc.)	0-		ce - America ck, White, e y: Wh	
21215-0020	ithin 72 h le. len *natu	Completed	15. Decedent's (Specify only highest of Elementery/Secondary (0-12)	rade completed) College (1-4or	5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)					rking 16b. Kind of Busines				
	hygien her th	S	0-12	6	a	ssis	tant	dir							ryalnd
Maryland	o d ala	To Be	17. Father's Name (First, Middle, La Ira Sc	ott Stottl	emyer				18. Moth		e (First, Middle rtha An				myer
Mar	2 0 0 5		19a. Informant's Name/Reletionship (Type, Print) Mrs. Betty Z. Stottlemyer/Wife 16725 Buford Dri												
altimore,	permit. Pages 1 end Department of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Content of the Content		amoval from State 20b. Place of Disposition (Neme of cemetery, crematory or other place) Rose Hill Cemetery						Date 'eb. 16			- City or To	wn, State Maryland
Balti			21. Signature of Funeral Service Lic		1	13	. Name and	Addr	ess of Facili	•	Minnio	h F	uner	al Ho	
	_		23a. Pert1. Enter the disease, or co shock, or heert failure. List on	mplications that cause	ed the deeth. De	- 1						-	COWII	, 1101	Approximete
	Physician /Medical Examiner	er	Immediate Ceuse (Final disease or condition resulting in deeth)	aa	Le poe to copas	2ul	uence of):		S	ed	leur Tel				Interval Between Onset and Death
o,	tificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. a	Due to (gras e consequence of): It acute meyocorded infarction have									your.	
x 68760,	9 = 0	Medicai	Cause (Disease or Injury that initiated events resulting in death) Last	c	Due to (or as e	conseq	uenca of):	0			U	/			
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P.0.	es that the digned by the be deteched	Physician	Part II. Other significent conditions contributing to death but not resulting in the unde						iven in Part	l.			obacco use contributa to the cause of death res 2. No 3 ☐ Probably 4 ☐ Unknow		
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Re	9 4 9	omp									10	Yes 2	No No		Yes 2□ No
Vital		BeC	25. Was cese referred to medical						26. Place	e of Deat	h (Check only				
of V	2 00	To	examiner? 1 ☐ Yes 2 No	Hospital:	ient 2 ER/0	Dutpetien	t 3 DOA	A Ot	her: 4 🗆 Ni	ursing Ho	me 5 Res	idence	6 🗆 Oth	er (Specify)
	ath. r: After		27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigeti	28a. Dete of Inju (Month, De	ury 28b	. Time of Injury	M 28	Bc. Inju Wo	ıryat ork?]Yes 2 ⊡		28d. Describe	how Inju	ury occur	red	
Division	or Attending P setter death. I Director: After the in by the funer.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)								281. Location (Street end Number or Rural Route N City or Town, State)				Route Number,
	Hospita 14 hours Funera tely fille	edicai C	29a. Certifier 1 Cartifying F (Check only one) 1 Cartifying F	thysician: To the best miner: On the basis of and manner st	of examination a	ge, death and/or inv	occurred at restigetion, i	t the ti	ime, date ar opinion, des	nd place, ath occurr	and due to the red at the time,	cause(s	s) and made,	anner as st and due to	ated. the cause(s)
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			11 1.1101	completed ceuse of	deeth (Item 23e MeLica	(Type,	Print)	נ ק	14	-	- MD	71	141	7 (
		•	31. Date filed (Month, Dill, Year)		er's Sign	1 6 8 8	ا به درا		inge	73 (0)	- CIP	-1	- (
	Sta Registi		FEB 17	1998	wia David	lson-7	index.								

Robert Nelson Stottlemyer



State of Maryland / Department of Health and Mental Hygiene 9 8 7379

		1. Decedent's Name (First, Middle, L					2. Date of Dea		3. Time of Deel			
Physicia: /Medica		JOHN ROS	SCOE SNY	der			Februa.	ry 22 19	98 11:40 A			
Examine		4a. Fecility Neme (If not Institution, g	iva street and number)			4b. City, Town, or Lo	ocation of Death					
		Northwest	Hospital	Center		Randalls	town	Balt	imore			
Funeral Director		219-14-7805	Sex 7. Ag 1 ☑XM 2 ☐ F	a (In yrs. last birthda 82 Yrs	Months Dev		8. Date of Birth (Month, Day Apr. 15	9. 1915 P	Birthpleca (Stete or Fore Country) A			
A ==		Usual Residence of Decedent 10e. State 10b. County		10c. City, Town or	Location				10d. Inside City Lin			
23a or 28a-f show	tor	MD Carro	11	Sykes	ville				1 ☐ Yes 2 🖾			
e not	Sire.	10e. Street end Number		-	10f. Zip Code			10g. Citizen of Whet Country?				
23a (aic	7309 Second Av	enue		21	784		United	States			
at', or items	by Funeral Director	11. Marital Status 1 🗷 Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorcad	12. Was Decedent Armed Forces? 12 Yes 2 1 If Yes, Give Yeer or Dates:	Ever in U,S. 1 No 1 943-46	3. Was Decedent of If Yas, specify Cu	Hispenic Origin? (Spuben, Mexican, Puarto Specify:	ecify Yes or No- Rican, etc.)		wherican Indien, Thite, atc. White			
netural, or items 23	Completed	15. Decedent's E (Specify only highast g.	Education	16a. De	16a. Decedent's Usuel Occupation (Give kind of work done during most of life. DO NOT use retired)			16b. Kind of Busine	ess/Industry			
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aminer		Immediate Ceusa (Final disease or condition resulting in death) e. Cunses tive Weath Failure Due to (or es e consequence of):										
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trens	Examiner	Sequentially list conditions,		Due to (or es e cons		20.0						
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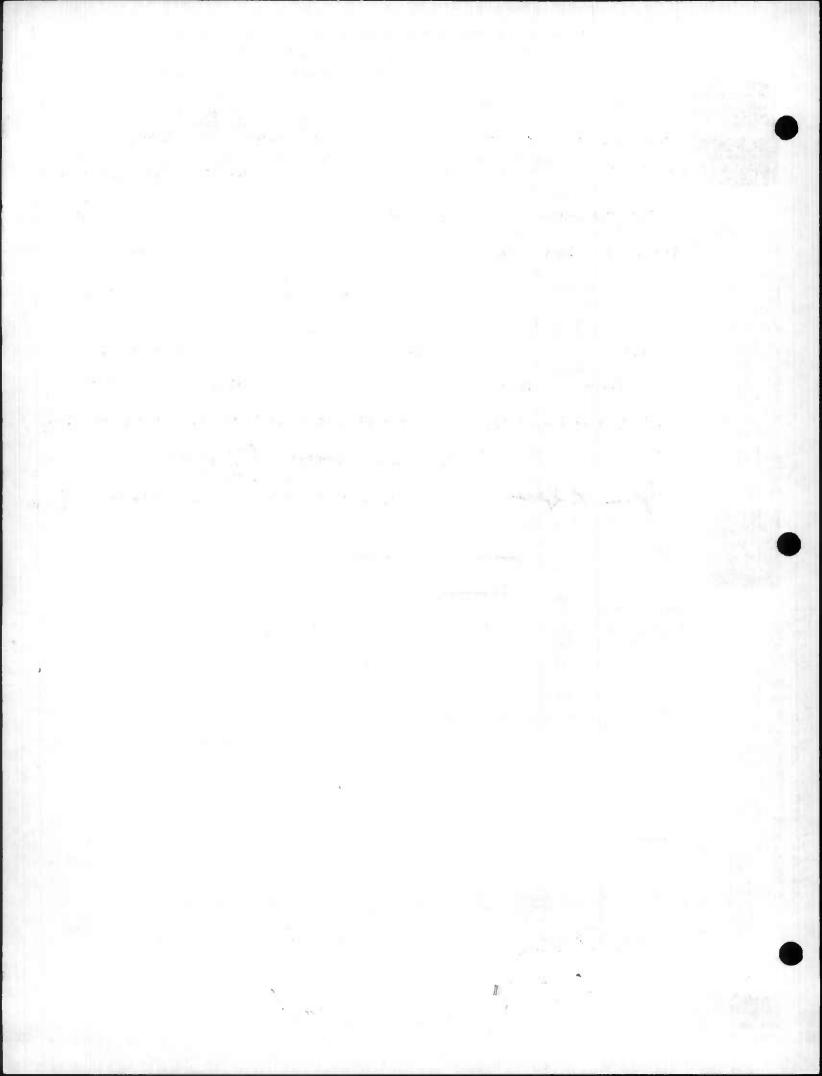
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate of	Death	F	eg. No.			
Physic	ian	1. Decedent's Neme (First, Mid		0144.0				2. Dete of Dee Month		Year 3. Time of D		
/Medi		Edith		OMAS				Februar	4 14	98 03:3	16	
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Funeral Director		5. Social Security Number 150-03-4399	6. Sax 7 1 ☐ M 2 ☑ F	. Age (In yrs. lest b		If Under 1 Yea Months Days		. (Month, Dey	Year)	9. Birthplece (Steta or Country) New York	Foreign	
p 3	1	Usuel Residence of Decedent 10a. State 10b. Coun	h	10c. City, Tov	m or Lor	nation				Land to the On	4.1.15	
show	5		ington	Hagers						10d. inside City		
the Mar 28a-f si	ect	10e. Street end Number	illigcon	nagera								
23a or	ral Dir	Maryland Wash 10e. Street end Number 11524 Green	Valley Driv	'e			21740		10g. Citizan of What Country? U.S.A.			
21215-0020 d within 72 hours after deeth with the Maryland glene. or than "natural", or frems 23a or 28s-f show in the Macieal Exampler must be notified at	by Funeral	11. Marital Status 1 □ Nevar Merried 2 □ Ma 3 ☑ Widowed 4 □ Divorce	Armed Force arried 1 Tes 2 If Yas, Give	2. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yas, Give Yeer or Detes:		13. Was Decedent of Hispanic Origin? (Spif Yas, specify Cuben, Mexicen, Puerto		Specify Yes or No- to Rican, etc.)	14. Race Black Specify:	- Americen Indian, , White, etc. White		
5-C	Completed	15. Decade	ent's Education lest grada complatad)	166	16e. Decedant's Usual Occupetion (Give kind of work dona during most of work lifa. DO NOT use retired)			orkina	16b. Kind of Bus	iness/industry		
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Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this cardificate has been signed completely filled in by the funeral director, page 2 should be	Certification:	3 ☐ Suicide 6 ☐ Coul	mined 200. Place of	f injury - At home, for , etc. (Specify)	erm, stre		Yes 2 No	28f. Location (Si City or Town	28f. Location (Street end Number or Rural Routa Number, City or Town, Steta)			
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- 3 - 0) 8	iledel Mas	1 10		Do	7857		2/1	4198		
		30. Nama and address of perso	n who complated cause	of daeth (Itam 23a)	(Туре, Р	Print)	ld. L	tag. M	L			
Sta Regista		31. Dete filed (Month, Day, Yea	7	Istra's Signature	Y	Berlato -		7				
1109.51		LD,	1 1000	1	and and	The same	*.					

Edith S. Thomas

Edith S Thomas

ITEMS: #2	23 F	PART I, 27, 28A-F PER MI	0 G762 WR			tificate of		nd Mental Hy	Reg. No.	U	1381
Physicia /Medic		Decedent's Nema (First, Middle, Last William L		ENT				2. Dete of D Month/ FCb.	Dey 13 19	Yaar	3. Time of Death
Examin	er	4e. Fecility Nama (If not Institution, give Washington County					4b. City, Town Hagers	n, or Location of Dea LOWN	th 4c.County Washi		
Funeral Director		100-42-7773	7. / 3 M 2 F	Age (In yrs. Ia 50	st birthday) Yrs.	If Undar 1 Yaar Months Deys		Min (Month, D	ay, Year)	Count	ece (Stata or Foreig ry) Sylvania
death with the Meryland ms 23a or 28a-f show rmat be northed at	tor	Usual Residance of Decedent 10e. Stete 10b. County Maryland Washingto	n			own or Location Stown					od. Inside City Limits ₹25Yes 2 □ No
n with the	Funeral Director	10e. Streef and Number 115 Catawba Place	Apt 5			10f. Zip Code	10g. Citizen of Whet Counfry U.S.A.				ry?
ours after deat	þ	11. Marifal Stafus 1 □ Nevar Married 2 Married 1 □ Nevar Married 2 Married 1 □ Yes 2 ☑ No If Yes, Giva Year or Detes:			1	Vas Dacedanf of I f Yes, specify Cub	n? (Specify Yas or N Puerto Rican, etc.)	o- 14. Rad Bla Specify	n Indian, ifc. te		
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it of		20a. Method of Disposition 1 ⊠ Buriel 2 ☐ Cremefion 3 ☐ F 4 ☐ Donetlon 5 ☐ Other (Spacify)	amovel from Stat	cer	pe of Disposition (Neme of elery, crematory or other place) Michael's Cemetery Date Feb. 20c. Location - Ci						vn, State
permit. Pa Departmar Important eny injury once.		21. Signe ure of Funarel Service Licens	ucer			Name end Address		Minnich Blvd., Ha			yland 21740
Physician /Medical Examiner	J.	23e. Perti. Enter the disease, or complishock, or heart failure. List only or Immadiate Cause (Finel disease or condition resulting in deeth)	e cause on each	ic Br	es e conseq	death		Taspitatory (u11931,	4	Approximete interval Between Onsef and Death
ficata be physicie is the bur	edical Examiner	Sequentially lisf conditions, if eny, leeding to immediate ceuse. Enler Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last	. Verdo	Sag e	es e consequent	h multi	ple a	gents			
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iclan: The lav certificate has rector, page 2		OF Was seen referred to modical							Yes 25 No	1 🗆	Yes 2 No
S 50	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospitel: 1 Inpa	tienf 2 E	R/Outpatien	t 3 DOA Ot	har	f Deeth (Check only ing Homa 5 ☐ Ras		er (Specify)
To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi complately filled in by the funeral	Certification:	27. Mannet of Deeth Manual 5 Pending investigation	28a. Dete of in (Month, D FOUND 2)	jury Pay Year) /11/98 U	8b. Time of Injury NKNOWN	28c. Inju Wo M 1	nyet ⊮k?]Yes 2.DXNo		how Injury occur	red	
ital or Att	Certifi	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined			ONKING			City or To		JNKNOWN	
Hosp 24 hou Fune Fune Idately fi	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Physical Control one) 2 ☐ Medical Examination	Iclan: To the bes er: On the basis and manners	of examinetio	edge, death n end/or Inv	occurred et the ti estigetion, in my	me, dete end ; opinion, deeth	pleca, end due to the occurred et the time	ceuse(s) end ma , date and place,	anner es ste and due to	eted. the cause(s)
To the To the comp	M	29b. Signeture end title of Sertifler	£		-	29c. Licens	se number	9	29d. Dete signe 2/13/	d (Month, E	Pey, Year)
		30. Name and address of person who co	mpleted cause of	death (Item 2	(Type, 1	Print) 1 Ave	4	ag . Md			
Stat Registra		31. Date filed (Month, Dey, Year) FEB 1 7 19	32. Regis	relia Dav		andelle		/			



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TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE be filed within 72 hours at IMPORTANT: If Item 2

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29a. CERTIFIER

2 MEDICAL EXAMINER: On the b

n signed by the attending physician and completely filled in by the . Health and Mental Hygiene prior to burial, cremation, or removal. has OR ATTENDING PHYSICIAN; The certificate t this c After DIRECTOR: At hours after de Item 28 is r

98 07382 FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 6:10 A.M JAY WILLMAN, JR. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign (Month, Day, Year) Dec. 14, 1935 217-30-7106 1 M 2 F 62 YRS. Pennsylvania 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 14134 Mann Lane Hagerstown Washington 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Hagerstown 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 14134 Mann Lane 21740 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

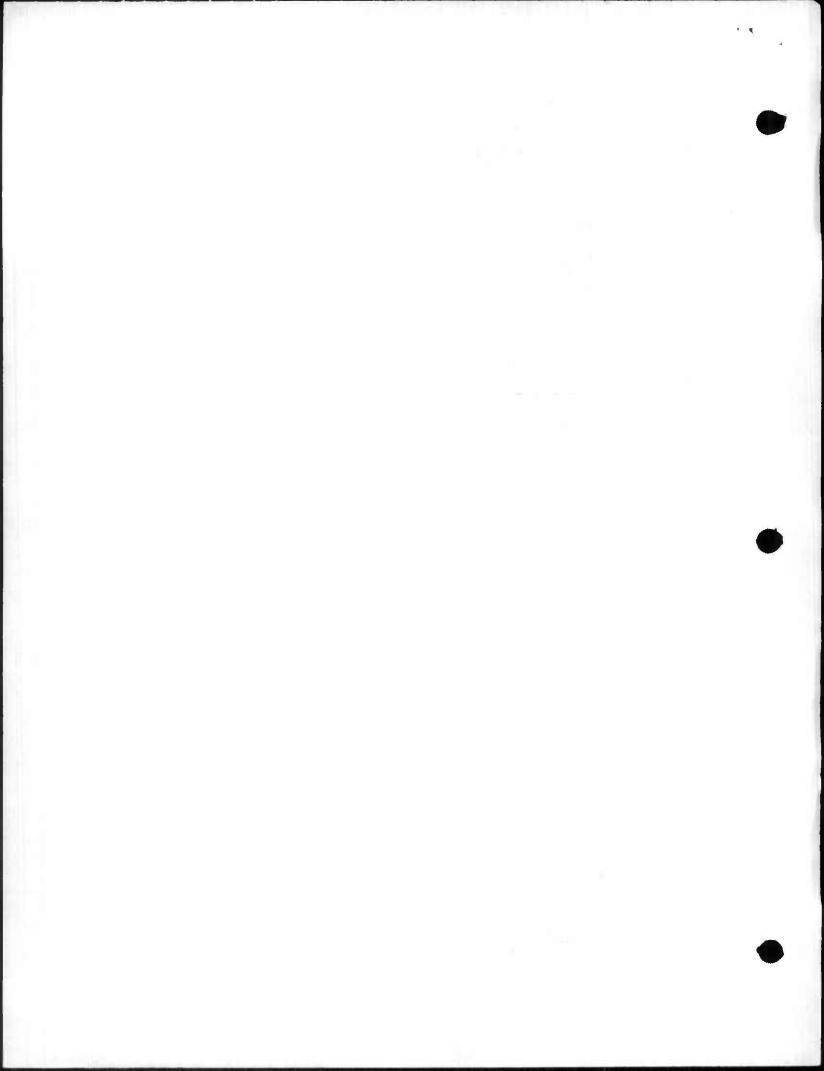
1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced Specify: White 16a. DECEDENT'S USUAL OCCUPATION ETED. 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify (Give kind of work done life. Do NOT use retired.) ntery/Secondary (0-12) College (1-4 or 5+) COMPL 12 Law Enforcement Officer County Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) C. Jay Willman 8 Elizabeth Musser 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Catherine Willman / Wife 14134 Mann Lane Hagerstown, Maryland 21740 20e. METHOD OF DISPOSITION
1 ☐ Burial 2 ◯ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Smithsburg Crematory Feb. 4 Donation 6 Other (Specify) 17,1998 Smithsburg, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home 21742 Mulalo 1331 Fastern Blvd. N. Hagerstown Maryland 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Interval Batween IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) QUAN OUL (2031 20 mon HS NO Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate CERTIFICAT cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY 100 T YES 2 NO 14/6 OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES YOUNG UNCERTAIN 🗆 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 | YES 2 | NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 4 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) COMPLETED 6 Could not be 4 Homicide

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, 62 30. NAM AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Dey, Year)

TR 1 8 1998 III MA 11110 bredice Compus 32. RESISTAAR LAIGNATURE Fundale

ation and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner ea stated.

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner es stated.



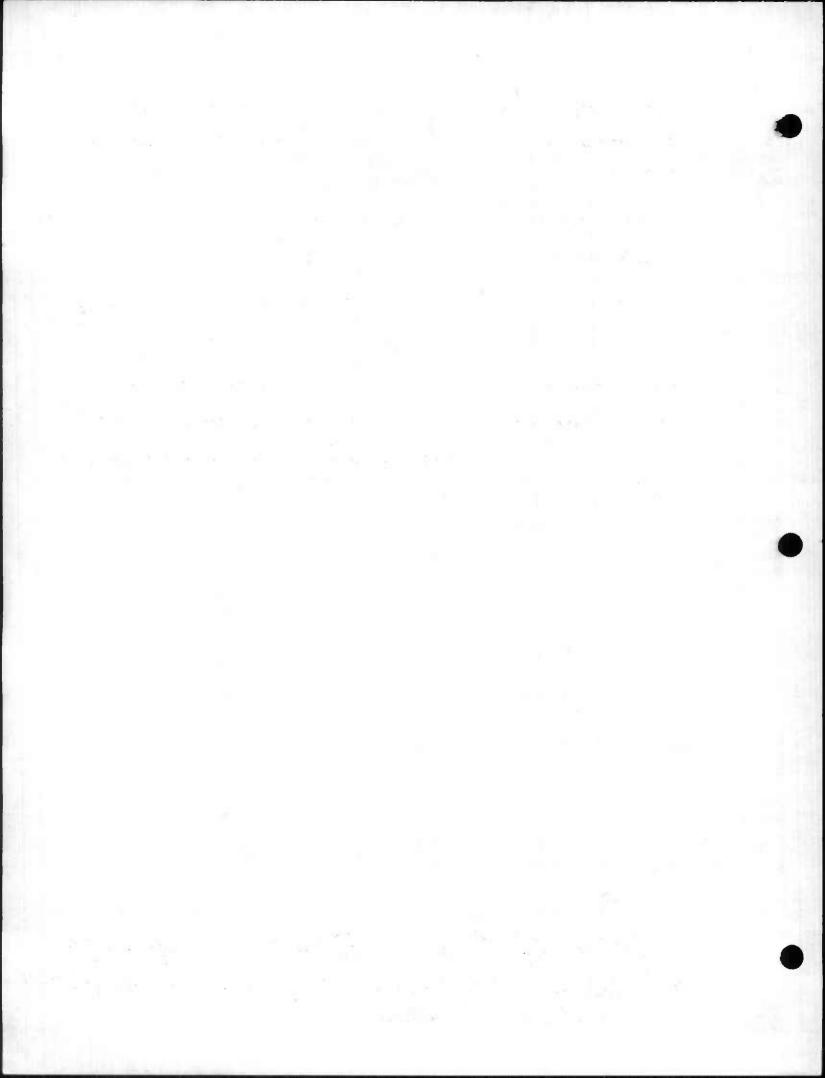
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 20, 1998 **Physician** February Mary Evelvn Wachter 10:30PM /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 12150 Wachter Rd. Union Bridge Frederick ff Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | (Month, Dey, Year) 5. Sociel Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Deys 1 □ M 2 🕅 F Sept. 214-76-4279 88 Yrs 1909 Director Usuel Residence of Decedent with the Marylend 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or itsims 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Frederick Director Maryland Union Bridge 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12150 Wachter Rd. 21791 U.S.A. nit. Peges 1 and 2 should be filed within 72 hours efter deeth 1 efforment of Health and Mentel Hygiene. ortant: If them 27 le marked other than "naturat", or thems 23, injury or other traumatic event, the Medical Experie Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No If Yes, Give Yeer or Detes: Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorcad White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) dairy 11 farm wife 17. Father'a Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be John E. Buffington Mary Elizabeth Boone 2 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) George M. Wachter/ son 12150 Wachter Rd. Union Bridge, MD 21791 Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Depertment of Important: If any injury or once. 2/24/98 nr. Ladiesburg, MD Haugh's Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licansee 22. Neme end Address of Fecility Hartzler Funeral Home 23a. Part 1. Enter the disease, or complications that caused the Seth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Union Bridge, MD 21791 **Physician** /Medical Immediete Cause (Final diseese or condition resulting in deeth) Examiner Examiner or Attending Physician: The law requires that the deeth certificate be executed efter deeth.

Director: After this certificate hes been signed by the attending physician and Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Box 68760, attending physician for use es the buria Physician/Medical Due to (or es e consequence of) signed by the a d be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 2 No 1 Yes þ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 1 ☐ Yes 2 ☐ No funeral director, Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) 1 Yes Other: 4 Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation To the Hospital or Attendin within 24 hours efter deeth. To the Funeral Director: Af completely filled in by the fu 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Medical Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basts of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) end menner stated. 29e. Certifier 29b. Signature and title of certifier NO. moleted cause of deeth (Item 23e) (Type, Print) J., Mão Briove 104 32. Registrer's Signature 31. Dete filed (Month, Dey, Year) State

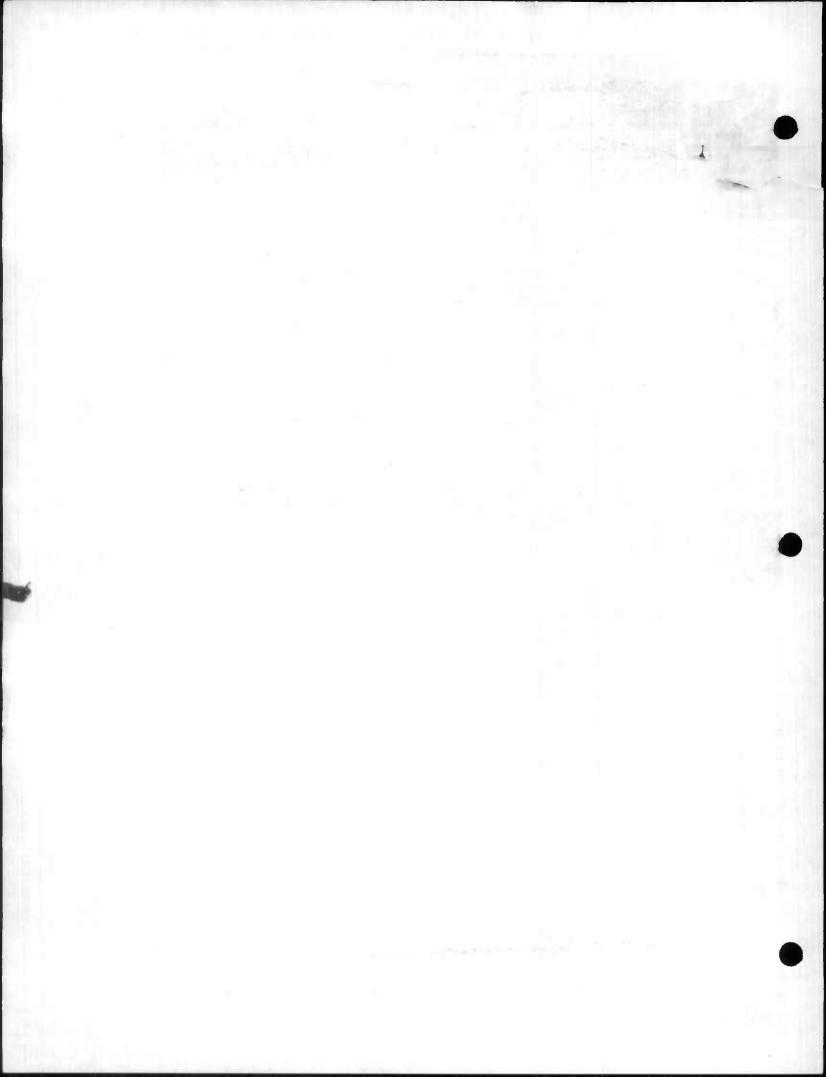
Registrar

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	Physic	ion	1. Decedent's Neme (First, Middle, Las					2. Dete of Deet		Year	3. Time of Death	
	/Medi		Charles Edwar	- Comment of the Comm		1		March		38,	2:05 AM	
5)	Exami	ner	4a. Fecility Neme (If not institution sive	street end number)			4b. City, Town, or L	ocation of Death	4c. County			
L			VA Maryland Ho	ealth Care	Syst yrs. lest birtho	em lav) If Under 1 Year	BALTIMO if Under 24 Hrs.			N/A		
Ļ	Funeral		220-20-4730 Usuel Residence of Decedent	2 F 69		Months Days	Hours Min.	8. Dete of Birth (Month, Day, AUG 28,	Year) 1928	9. Birthple Countr Geor	ece (Stete or Foreign y) gia	
	show ad at		10a. Stete 10b. County	100	c. City, Town o	r Location				10	d. Inside City Limits	
	death with the Maryland ms 23s or 28s-f show Livest be notified at	to	Maryland Anne	Arundel	P	asadena					1 ☐ Yes 2 No	
	ith the Mi	Director	10e. Street end Number			10f. Zip Code		11	Og. Citizen of V	Vhet Countr	ry?	
	23a c	alD	218 Magnolia	Avenue	ue				USA			
	items	by Funeral	11. Marital Stetus	12. Wes Decedent Ever in U,S. Armed Forces?		13. Wes Decedent of H If Yes, specify Cubo	ecify Yes or No-	14. Rec	e - America k, White, et			
020			1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 No V If Yes, Give	Yes 2□NoViet 1□ Yes 2		Specify:	Thour, otc.,	Specify		ite	
5-0	natural',	Be Completed	15. Decedent's Ed (Specify only highest gree	ucation	16e. D	ecedent's Usuel Occup	ation	16b. Kind of Business/Industry			istry	
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and			17. Fether's Neme (First, Middle, Last)	,			18. Mother's Nam					
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Ma	alth an 27 is r		Jean Pompanio/s			lailing Address <i>(Street</i> 2 Kinder						
	1 and Health em 27 other tr	ŀ	20e. Method of Disposition		oh Place of D	isnosition (Name of	1	illers	20c. Location -			
altimore,	ages int of t: if it		1 Buriel 2 Cremation 3	Removel from State	cemetery.	cremetory or other plea	1					
=	permit. Pages 1 a Department of Her Important: if item any injury or othe	-	4 ☐ Donetion 5 ☐ Other (Specify 21. Signeture of Funeral Service Licen.		metro C	rematory, 22. Name end Addre		6/98	Balti	more	, MD	
Ba	permit. Departrimportu any injuge.		· Warm of	Mc & mal	d	Crematic	on Socie				Inc.	
			23a. Part1. Enter the disease, or composhock, or heert failure. List only of	McDonalde	death. Do not	299 Fred	lerick R	oad Ba	altimo	re,	MD 21228	
	Physician		shock, or heert failure. List only o	ne ceuse on eech line.							Approximete Intervel Between Onset end Death	
	/Medicai		Immediete Ceuse (Finel diseese or condition	Lung Can	2 yrs							
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	and trans	Examiner	Sequentially list conditions,									
90,	cate be execut physician and the burtal-tran	9	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury				1					
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Box	to all o	clar										
P.O.	the de y the sched	Physician/M	Pert II. Other significent conditione co	contributing to death but not resulting in the underlying cause given in Pert I.				23b. Did tobacco use contribut				
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Division of Vital Records,	n sign	g D						24e. Was e		24b. Wer	e eutopsy findings	
8	w requin been si should	ete						perform	ned?	com	leble prior to pletion of cause eeth?	
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每		Be C	25. Was case referred to medical				26. Plece of Deet	- 10		10	Tes ZLINO	
2		To B	exeminer?	Hospitel:	2 ER/Outpa	atient 3 DOA Oth	or:	ome 5 Reside		er (Snecify)		
0			27. Menner of Deeth	28e. Dete of Injury (Month, Dey Yea		e of 28c. Injur		28d. Describe ho				
ō	ath.	atio	1 Divieturel 5 Pending 2 Accident investigation	(MOHIII, Day 100	1r) Inju		Yes 2 □ No					
N S	or Attending star bleath. Director: Atte in by the fund	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - building, etc. (S)	At home, ferm	, street, fectory, office		28f. Location (Sti	reet end Numb	er or Rurei	Route Number,	
9	led in the			ballanig, oto. (o)	,00,117			, c	, 01010,			
	To the Heaptlat or Attendi within 24 hours attardeath To the Funeral Director: A completely filled in by the t	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	sicien: To the best of my ner: On the basis of examend menner steted.	knowledge, d minetion end/o	eeth occurred et the tir r investigetion, in my o	ne, dete end plece, plnion, deeth occur	end due to the ce red et the time, de	use(s) end me ete end piece,	nner es ste end due to t	ted. the ceuse(s)	
	To the To the comp	-	29b. Signeture end title of certifler			29c, Licens	e number	25	d. Date signer	(Month, D	ey, Year)	
			1-7500	-		D P11	748		31	3/	78	
- 1			30. Neme and eddress of person who c	ompleted cause of deeth	(Item 23e) (Ty	pe, Print)		-	7/2/18			
5+			Kester Crosse	, MD., 22	S. Gr	eene Stre	eet, Bal	timore,	MD	2120		
	Sta		31. Date filed (Month, Dey, Year)	32. Registrar's S	ignature	Pandell	•					
	Registr	ar	MAR 1 0 199	10 Demons	on Intoles and							

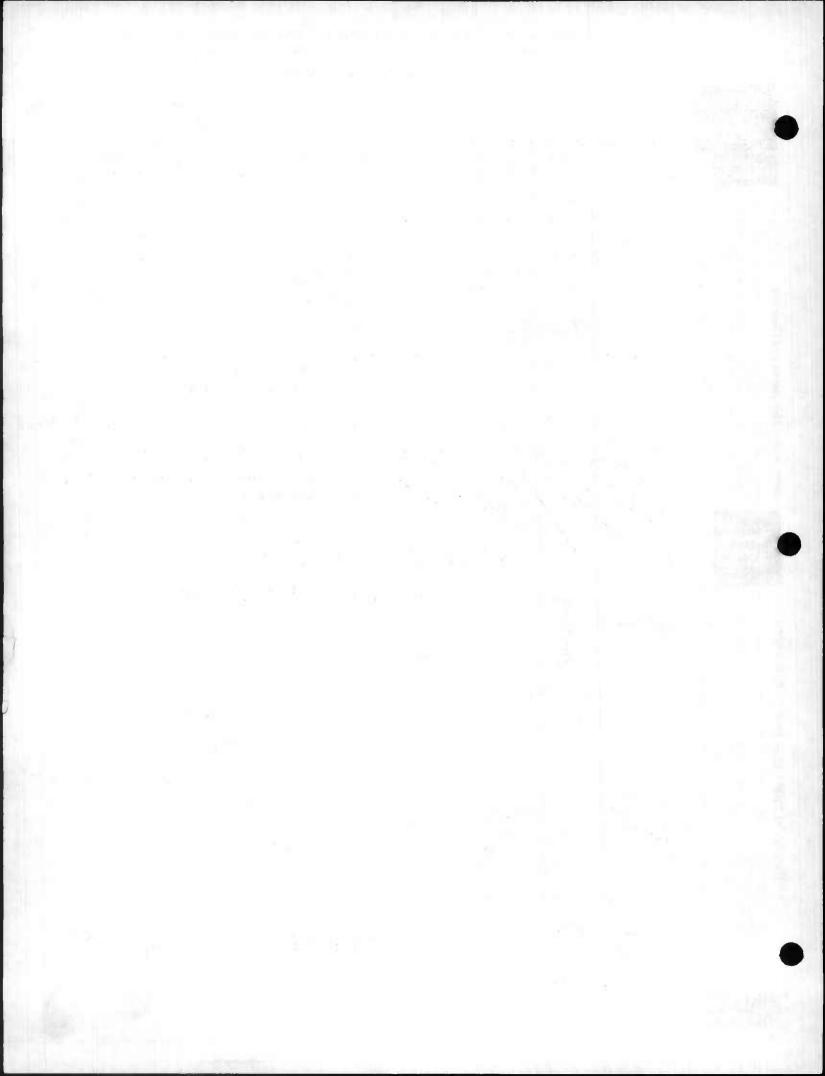
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First Middle Last) 2. Deta of Deeth **Physician** Month 3/7/98 Mae Willie Anstead 10:10pm /Medical 4e. Fecility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Prince Georges General Hospital Prince Georges Cheverly 7. Age (In yrs. lest birthday) If Undar 1 Yaar if Undar 24 Hrs. 5. Social Sacurity Number Birthplece (Stete or Foraign Country) **Funeral** Months Deys Hours 1□M 30% 61 Director 212-72-3446 Nash Co. NC Usuet Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at Md Prince Georges New Carrollton 1 Yes 2 XNo Director 10f. Zip Code 10a. Citizen of Whet Country? 8350 Verona Dr 20784 USA permit. Pages 1 and 2 should be filed within 72 hours efter deeth v Depertment of Health end Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or Items 23a any Injury or other traumatic event, the Med cal Examinar must Funeral 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Bteck, White, atc. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Stetus 1 ☐ Yes 2 ☑ № If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Black Specify: P 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 th Housewife 17. Fathar's Nema (First, Middle, Last)

Macco Harper Domestic 18. Mother's Neme (First, Middle, Melden Sumeme) Be Mary B Lynch 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Jackie Anstead Bullock 926 Palmor Rd Apt #5 Ft Washington Md20744 20b. Place of Disposition (Neme of Date 20c. Location - City or Town, Stete Burgess-Lynch Cemetery 3/13/98 Hollister NC 21. Signeture of Funeral Service Licensee Neme and Address of Facility Richardson Funeral Home Louisburg North Carolina florr, that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, cause on each line. Onset end Deeth **Physician** /Medical Immediete Ceuse (Finat diseese or condition resulting In death) Examiner Examiner buriel-tragsi Sequentially list conditions, if any, taading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of) ettending physician Box 68760. Physician/Medicai the Due to (or as a consequence of): USB Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t d be detect 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveileble prior to completion of ceusa of deeth? 24e. Wes en eutopsy performed? Completed peen hes page 2 certificate 1 Yes 2 No 1 Yes 2 No Physician: Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitat: Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 2 1 Yes 2 No After this funeral 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how Injury occurred 27. Menner of Death ne Hospital or Attending P n 24 hours after deeth. ne Funeral Director: After t Certification: 28c. Injury et Work? 1 DNaturet 5 Pending 1 | Yes 2 | Ne invastigation MA 2 Accident 6 Could not be 3 ☐ Sutcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide 29a. Certifiar Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner stated. To the vithin 2 29b. Signeture and Jiffe of certified 29d. Date signed (Month, Day, 1991) 30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print) LANDOVER RD #6 CHEVERLY MD m 31. Dete fited (Month, Dey, Yeer) 22 Register's Signeture State 01998 MAR 1

Registrar



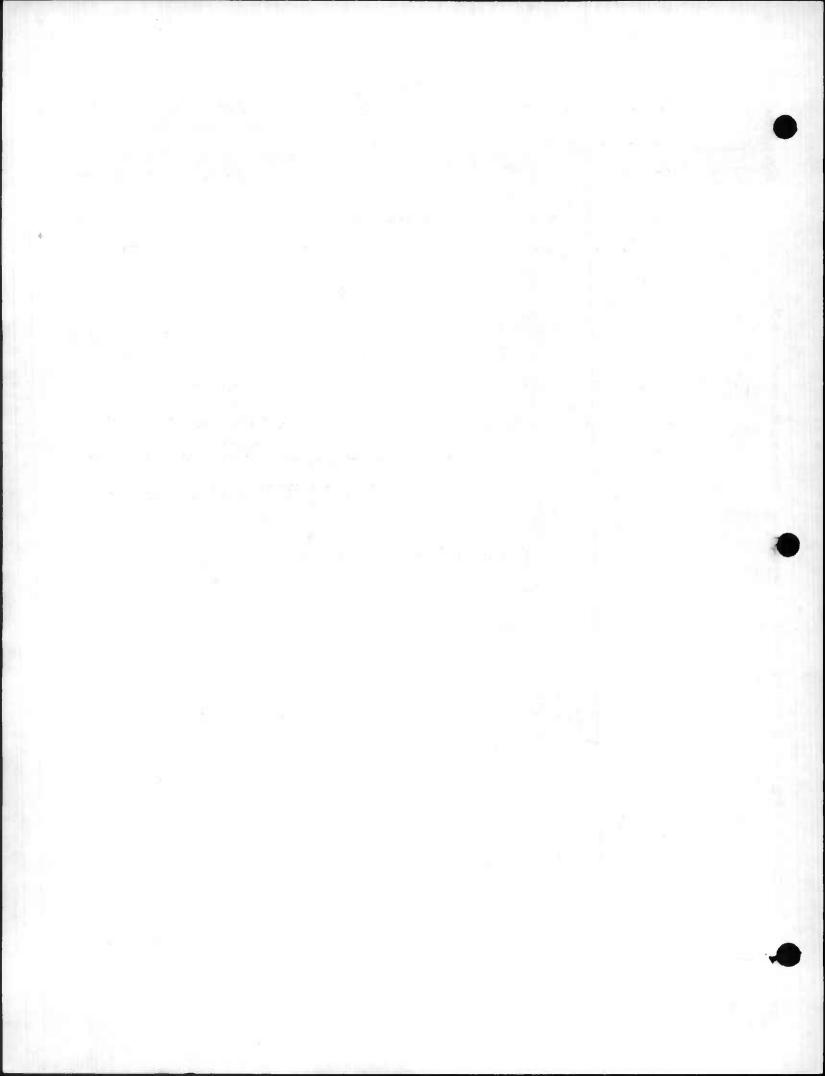
State of Maryland / Department of Health and Mental Hygiene Item: 18 per F.H. G-757 3/10/98 rebCertificate of Death

1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month CLARA В. **ABRAMS** MARCH 2 1998 10:15 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Baltimore n/a 1350 Andre Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Sept. 3 1916 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 1□ M 25 F 218-22-8264 81 Director Yrs. Mary land Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haelith and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modella Examiner must be notified as any injury or other traumatic event, the Modella Examiner must be notified as 10d. Inside City Limits Yes 2 No Director Md. n/a Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1350 Andre Street 21230 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Americen Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No tf Yes, Give Yeer or Dates: 1 ☐ Yes 2 HNo Specify: white Baltimore, Maryland 21215-0020 þ 3 1 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Salon of Grace College (1-4or 5+) Elementery/Secondary (0-12) Hair Dresser and Beauty 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Eva MvCarty McCarty Melville Grantland 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Jean A. Eckels (Daughter) 4741 Homesdale Ave, Baltimore, Md. 21206 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition March 20c. Location - City or Town, Stete 1 Bunal 2 Cremetion 3 Removel from Stete Glen Haven Memorial Park 1998 4 ☐ Donetion 5 ☐ Other (Specify) Glen Burnie, Md. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility McCully-Polyniak Funeral Home 130 E. Fort Ave. Baltimore, Md. 21230 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) Examiner Zweeks Examiner Sequentielly list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequenca of): Turinto Physician/Medical the Due to (or as e consequence of): Records, P.O. Box 687 88 signed by the atte Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24e. Wes en eutopsy Completed peen has 1 Yes 2 No 1 ☐ Yes 2 No After this certificata Division of Vital Hospital or Attending Physician:
 124 hours after death.
 Funeral Director: After this certifics. 25. Wes case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident illed in by tha 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyeictan: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as ateted.

2 Medicat Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end menner steted. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medicai 29b. Signature and title of cartifier D05631 MD, FACA 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Ma

State Registrar



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death **BROTHERS** 1998 6:38 PM H MAR 4b. City, Town, or Location of Death BALTIMORE 4a Facility Name (If not institution, give street and number) 4c. County of Death MANOR CARE NURSING HOME N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) AUG.9,1916 5. Social Security Number 9. Birthplace (State or Foreign Months Days NEW YORK 81 Yrs. 058-10-1459 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County N/A BALTIMORE 1 Nes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6302 LINCOLN AVE. 21209 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 Yes 2 ZNO If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry DAVID H. BROTHERS Elementery/Secondery (0-12) Cottege (1-4or 5+) ELECTRONIC CO., INC. 12 PROPRIETOR 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) **BROTHERS** FRANCIS STEEL 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6302 LINCOLN AVE. MIRIAM BROTHERS (WIFE) BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State BETH JACOB 3/5/98 FINKSBURG, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servica Licenses 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) angrene bue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ascular Oneva bue to (or as a consequence of) resulting in deeth) Last 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? completion of ceuse of deeth? 200 No 1 Yes 2 No 26. Place of Deeth (Check only one) Hospital: Other: 4 Sursing Home 5 Residence 6 Other (Specify)

/Medical

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show tre Medical Examiner must be notified at

with the Maryland

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filed within 72 hours aftar Hygiana.

other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other treumatic event once.

DAVID

10a. State

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11. Maritel Status

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Physician Examiner

Box 68768,

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within 2

Physician/Medical Examiner by Completed Be Lo Certification:

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29a. Certifie

(Check only one)

25. Was case referred to medicei examiner? 1 Yes 2 No

27. Manner of Death 1 Naturel 5 Pending Investigation 2 Accident

6 Could not be determined 3∏ Sulcide 4 Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of tnjury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Yes 2 No

281. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, end due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and Aitte of cartifier MO

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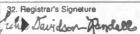
30. Name and address of person who completed cruse of death (Item 23a) (Type, Print)

MANOR CARE NURSING HOME BALTO., MD

Registrar

31. Dete filed (Month, Day, Year)

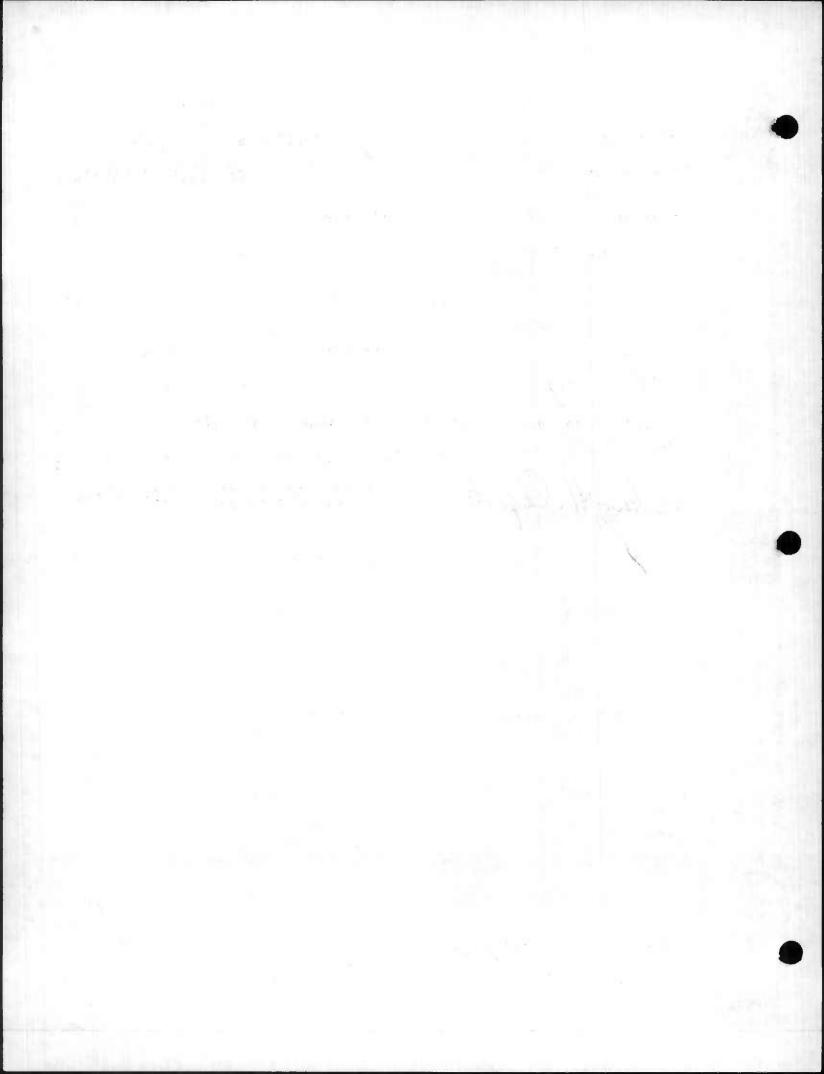
1 0 1998



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** James C. Burnham, Sr. March 1998 AM 1 9 /Medicai 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1304 Asbury Road Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Days Hours XXM 2 F 216-20-0580 7 1 Yrs. Director Jan 14,1927 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exaction nant be notified at Director 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1304 Asbury Road 21209 items 23a USA Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: W W I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after c Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Experiment once. 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X XNo Specify: þ 3 Widowed 4 Divorced white WWII Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Aerospace 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Henry Clay Mary Ann Crehan 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1304 Asbury Road Baltimore, MD 21209 Dorothy Jean Burnham (Wife) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete ₩Burial 2 Cremation 3 Removel from Stete Druid Ridge Cemetery 3/5/98 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licens 22. Name end Address of Facility Burgee-Henss Funeral Home, P.A. 3631 Falls Road Baltimore, MD 21211 ey or complication, that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arreat, List only one cau is on each line. Approximate interval Between Onset and Death Physician /Medical Immediate Cause RCINOUN 10 years disease or condition resulting in death) **Examiner** Examiner physicien end the burial-trensit that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by the eterios clerofic Cardiovascu 1 Yes 2 No 3 Probably 4 Unknown Records, þ The lew requires been sig 24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? Completed 24a. Was an autopsy performed? pege 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: Be director 25. Was cese referred to medice! examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No by the 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.
2 Medicel Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Edgeur / h.D. 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 711W40 Street BALTIMOR MD 21211 Sheldon Goldgerec M: D 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State Ichia Davidson-Randelle Registrar

DHMH 16 Rev 6/95

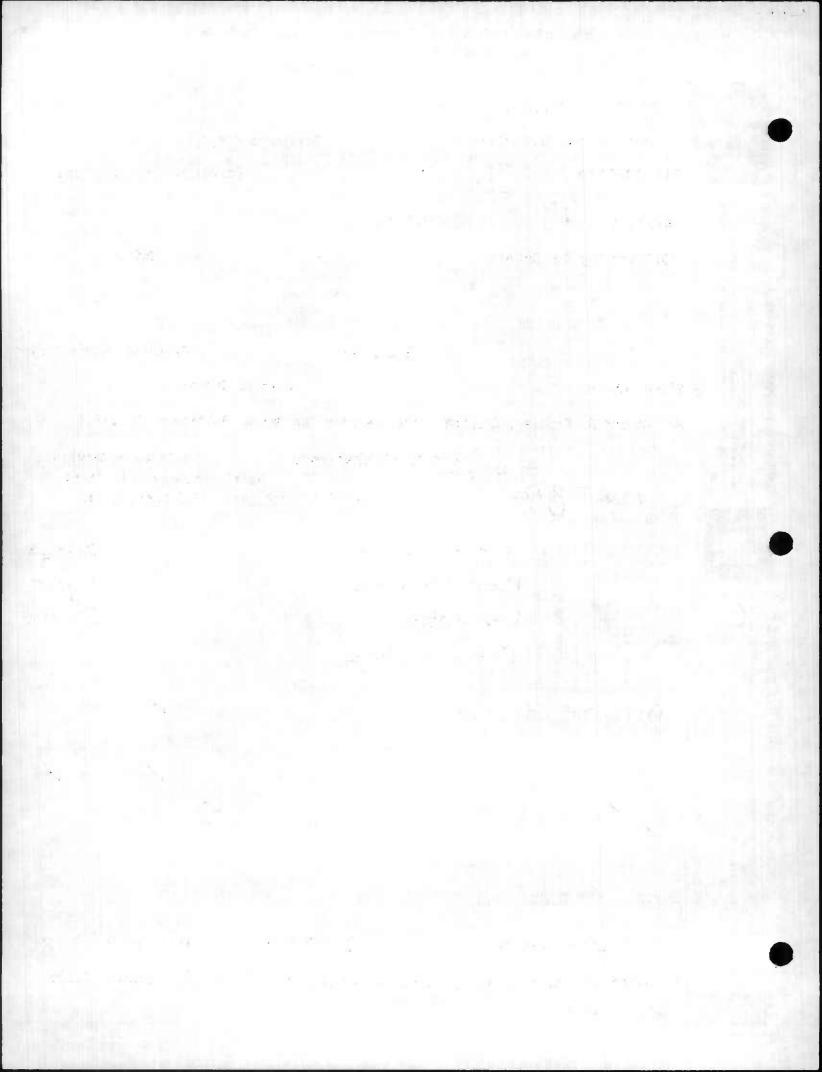


State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** March 9, 1998 MARIE 8:00 AM MARGARET BRADLEY /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4925 Herring Run Drive Baltimore City N/A If Under 1 Yeer | If Under 24 Hrs. | Months | Deys | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1 ☐ M 2 🔀 F Months 101 Yrs. October 25, 1896 Director 215-24-5845 Maryland Usuel Residenca of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Menyland neat of Health and Mentel Hyglene.
ant: if tem 27 Is marked other than "natural", or items 23s or 28s-f show may or other transmite event, In. Medical Exerting rount be notified at mry or other transmite event, In. Medical Exerting rount be notified at 10c. City, Town or Location 10d. Inside City Limits 10e Stete 10b. County 1 Yes 2 No Director Baltimore Maryland N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? United States 21214 Funeral 4925 Herring Run Drive 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispenic OrigIn? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Clothing Manufacturing Seamstress 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Justina Kunkel Simon Schuler 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 4925 Herring Run Drive Baltimore, MD 21214 Mr. Howard R. Bradley, Jr./Son 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 X Burial 2 Cremetion 3 Removal from State permit. Page Department of Important: If any injury or page. 3/12/98 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cemetery 22. Name and Address of Facility Baltimore, Maryland 21. Signature of Funeral Service Licensee Mark T. Zavoyna Mark T. Zarge Leonard J. Ruck, Inc. 5305

23a. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. 5305 Harford Rd. Approximate Interval Between Onset and Deeth **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examiner year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest ear Division of Vital Records, P.O. Box 68750 edicai Extreme Physician/M Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Probable Stroke Aq 24b. Were autopsy findings evalleble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? certificate has b lirector, page 2 s 1 Yes 2 No 1 Yes 2 No Be 25. Wes case reterred to medical 26. Piece of Death (Check only one) To 1□ Yes 2☑ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: or Attending 1 Naturel 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide .5 Hospital or 24 hours aft
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letely filled in 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) end manner as stated. Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier 29c. License number 040277 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 5601 Luch Roven Blud Baltimore 21239 Thomas S. Wilsonmo 31. Date filed (Month, Day, Year)

Registrar

Juna Javidson History



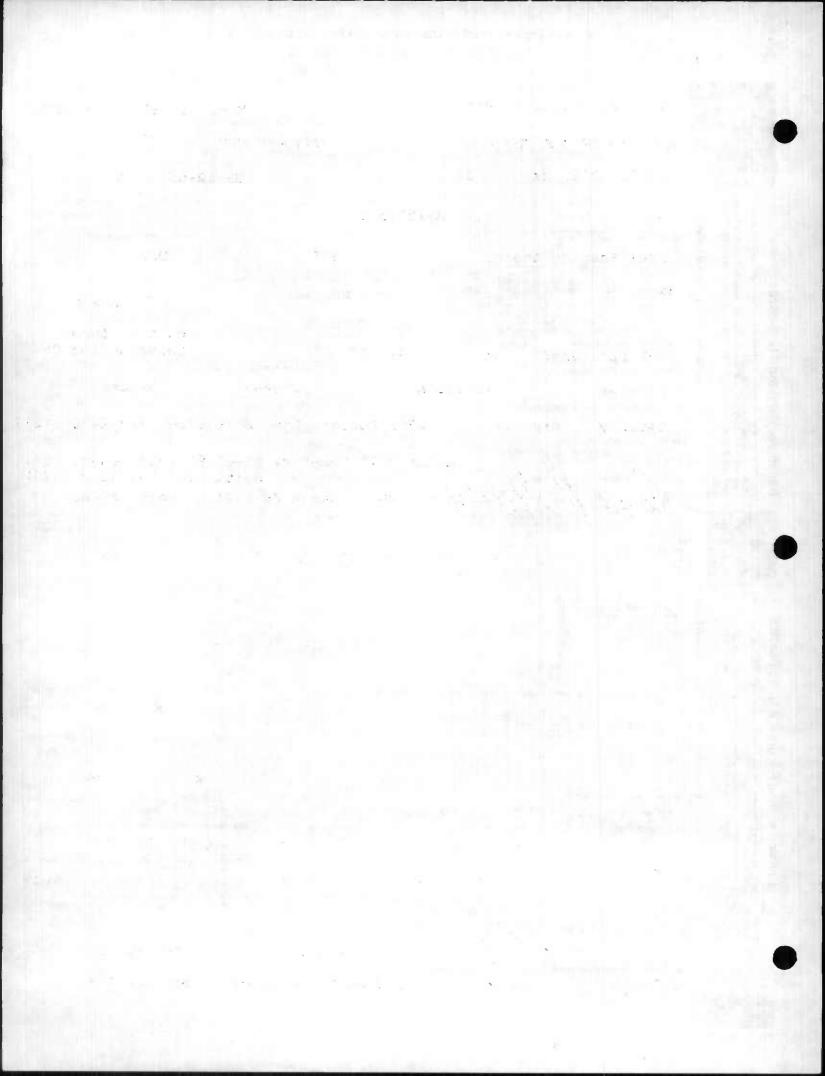
State of Maryland / Department of Health and Mental Hygiene

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iner	4a Facility Name (If not institution, gi	ve street end number)			4b. City, To	own, or Locat	ion of Deeth	4c. County	of Death					
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			Months			24 Hrs. 8.	B. Date of Birth (Month, Dey, Yeer)		9. Birthpli Count	aca (State or Foreign				
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by F	XXNever Married 2 Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2¥	No Specify:			Specify	/: p1	ack				
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To Be	LeVerne	Mayf	a Barnes											
-	19a. informant's Name/Relationship		Code)											
		Beverly Gregory 8891 Fontana Lane Baltimore, Maryland 212												
	20a. Method of Disposition		Ob. Plece of Disposemetery, cre				Date 2	Oc. Location -	City or To	wn, Stete Md.				
important; if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Madical Examiner mail be nothed at once. To Be Completed by Funeral Director	1 🔀 Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	_Hemovar from State				02				ndel Co,				
	21. Signature of Funeral Service Light			22. Name and A						nd 21202				
	1/2 1/	March.	1.						-					
_	WM.C. March FH 1101 E. North Avenue 23a' Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. Approximete interval Between													
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Net.	4 Homicide	building, etc. (S)	6(00	K		13	allimore		who.	· Genter				
edical C	29a. Certifier 1 Certifying P. (Check only one) 2 Medical Exa	hysician: To the best of my miner: On the basis of exa and menner stated.	knowledge, dee	th occurred at t	he time, date er my opinion, dec	nd plece, and	due to the ca	use(s) end m	anner as st end due to	ated. the cause(s)				
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	30. Name and address of person who	and a							2 220	20.1				
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82. Registrar's Signature

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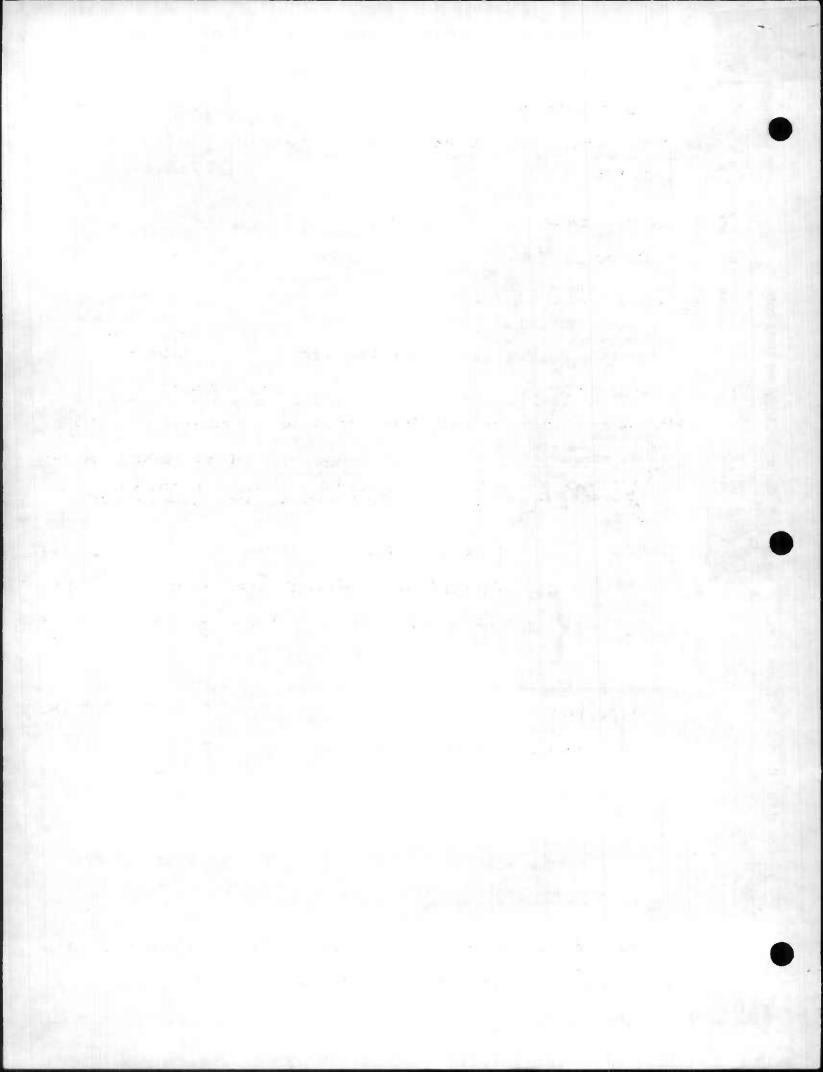
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þ		Widowed 4	4 □ Divorced	If Yes, Giv Year or De		10	☐ Yes 21区N	o Specify:		Specify	White
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ortant: if item 27 is me injury or other traums e.	Vir	rinia	Anne Mar	tin (Da	ighter)	3608	Nichole	son Rd.	Westmin	ster. MT	21157
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Deeth Month **Physician** :45 PM 98 Bernice M. Berry /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Nama (If not institution, give street end number) Examiner Baltimore HOSPita RON DECOUR NA If Undar 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthpleca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 F 212-22-3745 Yrs. Director UNE 8 1916 Usual Residence of Decedent with the Maryland 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or itama 23a or 28a-f show the Medical Experiment must be notified at Batto 1 Yes 2 10 No Owings Mi Directo ma 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number USA 21117 212 terslea Court Funeral filed within 72 hours after death 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Rece - American Indian, Black, White, etc. 11. Marital Stetus 1 Yes 2 NHO
If Yes, Give
Year or Detes: 1 Naver Merried 2 Married Bloc 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced p Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) -LC HOME 10th NA other 17. Fathar's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health end Mental Hy Important: if Item 27 is marked othe any injury or other traumatic event DDEs. 18. Mother's Neme (First, Middle, Meiden Sumeme) Aude lackson E. NIOSES MAR 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 11/12 KittERSIEA (Md 21117 212 Daughter WINGS N Laws-Jarbara 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 200 Location - City or Town, Stete 20e. Method of Disposition Date 1 ■ Buriel 2 □ Cremetion 3 □ Removel from State uid Ridge Com. 3/10/98 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility 219 m C. March torre Ave. 1215 4300 23a. Part. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shoot, or heart tenure. List only one ceuse on each line. Approximete Intarval Between Onset and Deeth Physician /Medicai Immediate Ceuse (Final disease or condition resulting in death) **Examiner** YEARS Physician/Medical Examiner DILATED CARDIO MYOPATHY the attanding physician and thed for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events Due to (or es e consequence of) Box 68760 Due to (or as e consequence of): that the daeth certificate resulting in deeth) Lest 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause givan in Pert i. signed by to 1 Yas 2 No 3 Probably 4 Unknown þ Division of Vital Records, The law requires 24b. Were eutopsy findings evaileble prior to 24e. Wes en eutopsy performed? Completed peen s completion of cause of deeth? certificate has 1 🗆 Yas 2 12 100 1 Yes 2 No or Attending Physician: 25. Wes cese referred to medical examinar? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Impaliant 2 ER/Outpetienl 3 DOA this funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 1 Maturel 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: After t 5 Pending investigation I Director: Af 1 Tes 2 No deeth. 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29a. Certifier 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated. (Check only one)

State Registrar

31. Dete filed (Month, Day, Year) 01998

A. K. CHOPRA

29b. Signeture end title of certifier

Julia Degistrer's Signature

S. CATON

Kum

1421

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

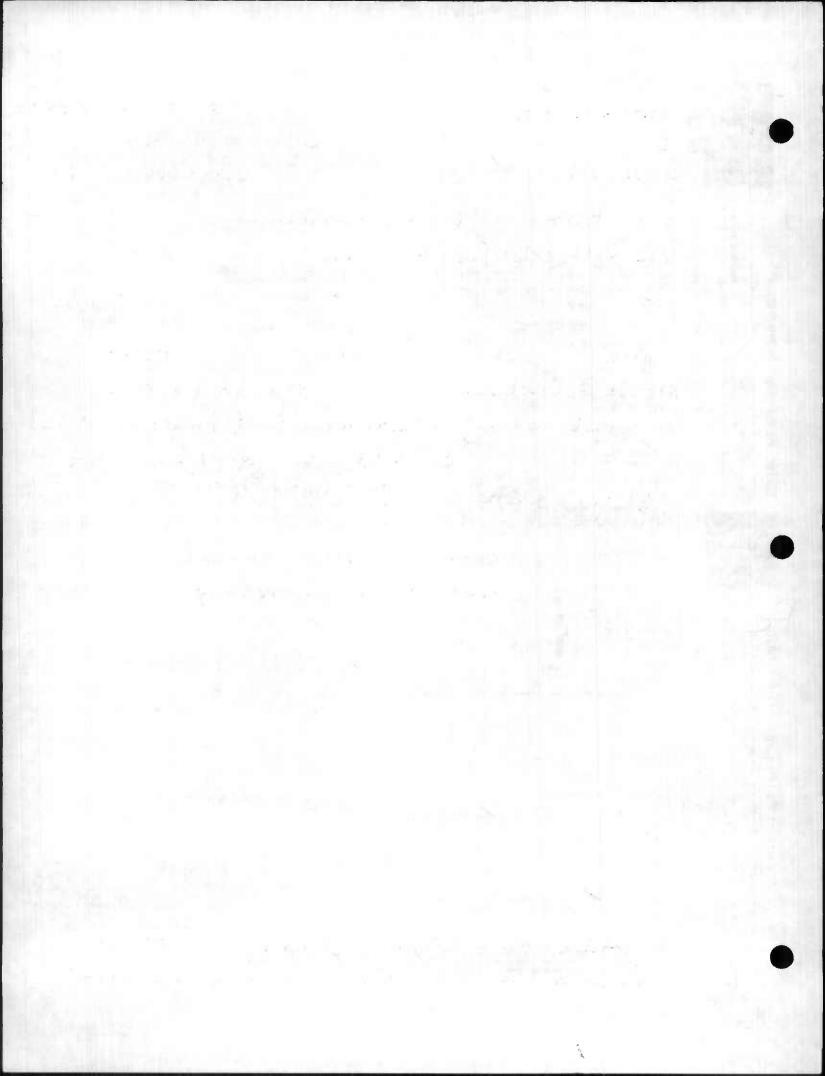
29c. License number

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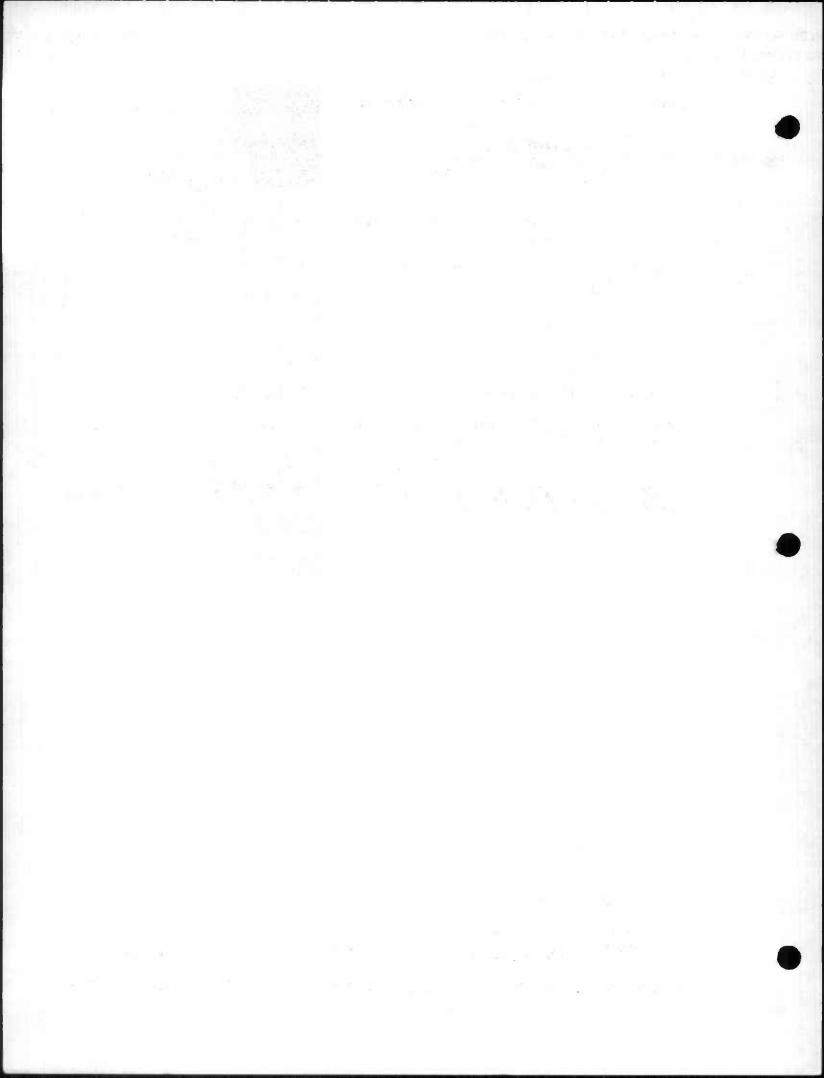
29d. Dete signed (Month, Day, Year)

BALTIMORE, MD. 21227



State of Maryland / Department of Health and Mental Hygiene 98 07393

					Certificate o	f Death	Re	g. No.	31030
	Physici	an	1. Decedant's Name (First, Middle, Last)	IENDY	DI AOMELI	70	2. Dete of Death Month	1	3. Tima of Death
	/Medic			IENRY	BLACKWELL	JR.	MARCH	07, 1998	6:30 A. M.
	Examir	er	4e. Facility Neme (If not Institution, give stre	A STATE OF THE STA		4b. City, Town, or L		4c. County of Dee	th
_			5. Social Security Number 6. Sex	S STREET 7. Age (In yrs. last)	hirthdey) If Under 1 Ya	SALTI ar if Undar 24 Hrs.	HORE OF BINT	\(\mathcal{V}\)	14
	Funeral Director			2□F 65	Yrs. Months Day		8. Data of Birth Month, Dey, AUG, 29	1932 NOK	thplece (State or Foreign buntry) RTH CAROLINA
	ylend now		10e. Stete 10b. County	10c. City, To	own or Location				10d. inside City Limits
	ter deeth with the Maryler thems 23s or 28s4 show ther must be not od at	Director	HARYLAND N /	A	BA.	LTIMOR		d. Citizen of What Co	1€ Yas 2□No
	3a or		0	S STREET		2122		451	
	deeth	Funeral		Wes Decedent Ever in U.S.		f Hispanic Origin? (Spuben, Mexicen, Puerto		14. Race - Ama	aricen Indian,
020	ours at	þ	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detas:	1 ☐ Yes 2 ☑ N		Hican, etc.)	Bleck, White	LACK
5	n 72 hours "naturel", edical Ex	etec	15. Decedent's Educeti (Specify only highast grede co	on 16	Se. Decedent's Usuel Occ (Give kind of work dor life. DO NOT use reti	cupetion ne during most of work	ing	6b. Kind of Business	/Industry
121215-0020	J withir Jiene. T than	Completed	9 + H GRADE	College (1-4or 5+)	LABC	PRER	F		IVERS LOCAL UND
and	d la b	Be	17. Fether's Nema (First, Middla, Last)	10,0000			e (First, Middle, M	0	
Maryland	d 2 should be the nd Mental 7 Is marked of treumatic ev	2	19a. informant's Neme/Reletionship (Type,	BLACKWE	9b. Meiling Address (Stre	BESS			ZE Code)
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re,	of Heelth of Heelth I Item 27 r other tr		20a. Mathed of Disposition	20b. Piece	of Disposition (Neme of tery, cremetory or other p		Dete 2	Oc. Location - City or	Town, Stete
E			1 ☐ Burial 2 ☐ Cremetion 3 ☐ Rem 4 ☐ Donetion 5 ☐ Other (Spacify)	ovei from State			3-11-98 L	ANSMUN	UE, HARYLAND
Baltimore	permit. Pag Department Important: I any Injury o		21. Signeture of Funerei Sarvice Licensee	R n -		BROWN JR.			
			23a. Pert1. Entar tha diseese, or complicet shock, or heert feilure. List only one of	ons thet caused death. D	o not enter the mode of d	lying, such as cardiec	or respiretory erres	st,	Approximete
k	Physician		snock, or neer tellure. List only one of	euse on eech lie					Onset end Deeth
ı	/Medical Examiner		Immediate Causa (Final disease or condition resulting In death)	PROST.	ATE (CANCE	12		4 years
	LAGIIIIICI		resulting in deeth)	Due to (or es	e consequence of):	71			
_	nsit	Examiner	b		e consequence of):				1
2	ic. in end burial-transit	Еха	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying						
76		edicai	Ceusa (Diseese or injury that initiated events c						
Box 687	death certificate e attending physical ed for use es the	5	resulting in deeth) Last		e consequanca of):				
	death cer e attendir ed for use	Physician/	Part II. Other significant conditions contrib	uting to death but not resulting	in the underlying cause	given in Pert I.	23b. Did tob	acco uee contribut	to the cause of death?
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	8 5 8	by							
Vital Records,	v requires been sign should be	ted					24a. Wes an perform	ed?	Wara eutopsy findings aveileble prior to
ec Se	2 S S	Completed							completion of ceuse of deeth?
E E	T age						1 ☐ Yes	s 2 No	1□Yes 2☐No
<u>=</u>	Physician: The rthis certificate ral director, pag	Be	25. Wes case referred to medical examiner?	pital:		Whor:	h (Check only one		
ō	Phys this ral di	2:10	TIL TES ZILVINO	1 ☐ Inpatient 2 ☐ ER/	Jutpatient 3L DOA	4 Li Nursing Ho	ome 5 D Tesiden 28d. Describe hov	nca 6 Other (Spe w injury occurred	ocify)
o	Attending For death.	ation	1 Netural 5 Pending 2 Accident Investigation	(Month, Dey Year)	injury W	lork? □ Yes 2 □ No			
Division	2 th 2 in	Certification:	3 Suicide 6 Could not be	8e. Place of injury - At home, building, etc. (Specify)	ferm, straet, factory, offic	DB	28f. Location (Stre City or Town,	eet and Number or Ri Stete)	ural Route Number,
	Hospital 24 hours Funeral stely filled		29e. Certifier 1 Pertifying Physicia	n: To the best of my knowled	ge deeth occurred at the	time date and place	end due to the ceu	use(s) and menner e	e etatad
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai		On the basis of exemination and menner stated.	end/or investigation, in my	opinion, deeth occur	red et the time, det	e and place, and due	to the cause(s)
	vithin To th	Me	29b. Signature end little of certifier			nsa number		d. Data signed (Mont	
			> unal	if he	- D'	2907/		2.9-98	
	9		30. Name and eddress of person who comp	eted cause of deeth (Item 23s) (Type, Print)			, 14	0.2
	l		R. KRISHNAN, M		EUTAW S-	1 #505	BALTI	3.9-98 MORE M	04201
	Sta Registr		31. Data filed (Month, Dey, Year) MAR 1 0 1998	32. Registrer's Signeture	-Pandell				



98-1127-510 jhm ROBERT

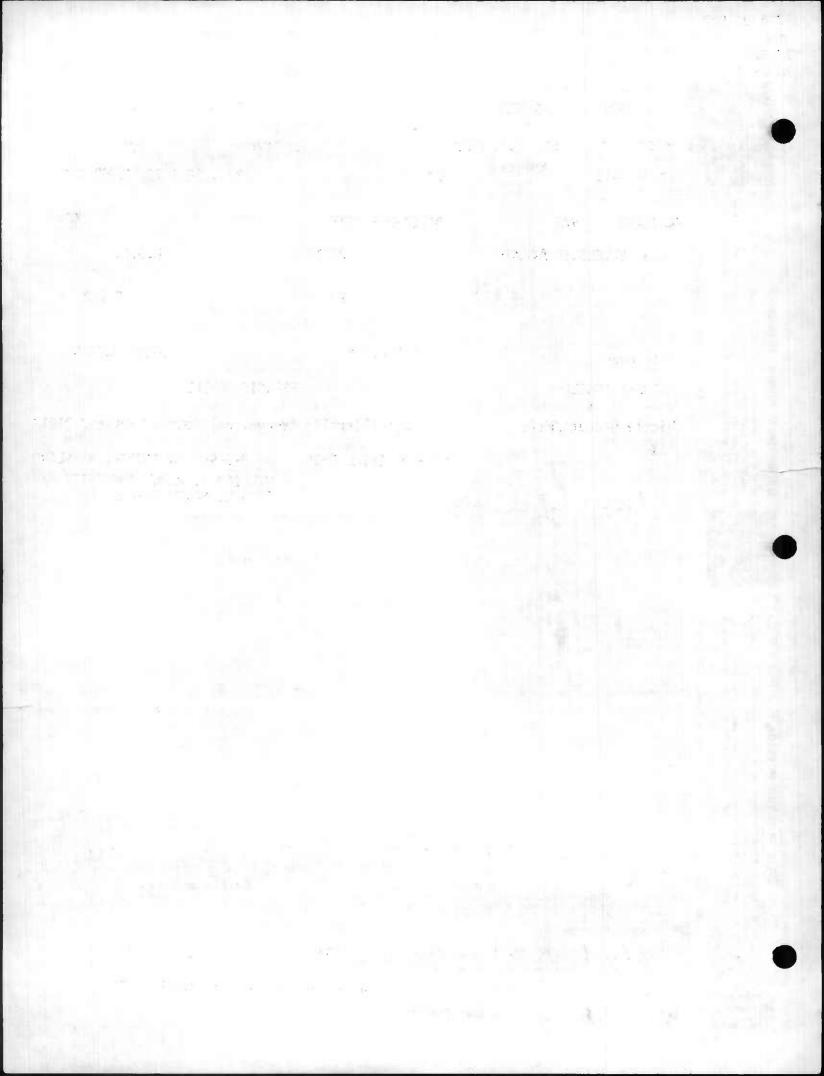
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State of Maryland / Department of Health and Mental Hygiene Q Q Q Q Q

ENNETT			Otato of Maryla		ertifica				Reg. No.	U,	1394	
81		1. Decedent's Name (First, Middle, La	est)					2. Dete of Der Month		Year	3. Time of Death	
	sician edical	ROBERT E	BENNETT					MARCH (1, 1998	3	00:10 AM	
	miner	4a Facility Name (If not institution, given	re street and number)				4b. City, Town, or	Location of Death	4c. County	of Death		
Fune Direc			Sex 7. Age (In yrs	. last birthdi 24 Yrs	Months	Days	RALTTMOI If Under 24 Hrs Hours Min	8. Dete of Birth Month, De	N N, Year) 8 1973	9. Birthp Coun MARY	lace (Stete or Foreign try) LAND	
pu .		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or	Location					1	Od. Inside City Limits	
Aeryle 7 sho	ò				ORE C	ττν				1 X Yes 2 □ No		
the the	Director	MARYLAND N/A 10e. Street and Number		DALIT		ip Code			10g. Citizen of V	What Coun	fry?	
3 with	ā	3304 ELLERSLIE	AVENUE			212	18	U.S.A.				
Maryland 21215-0020 d 2 should be filed within 72 hours after deeth with the Meryland th end Mental Hygiene. The marked other than "natural", or items 23a or 28a-1 show than 10 to	by Funeral	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes X No If Yes, Give Year or Detes:	1 ☐ Yes X X No If Yes, Give 1 ☐ Yes			lispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No rto Rican, etc.)	o- 14. Race - American India Black, White, etc. Specify: BLACK		etc.	
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ylanc buld be fi Mental H arked off	Be	ROBERT POWELL					IS POWEL		10)			
should and Men	70	19a. Informant's Name/Reletionship	Type Print)	19b. Malling Address (Street and			and Number or Rurel Route Number, City or Town, Sta			State, Zip	ate, Zip Code)	
		Nicole Bennett/W									nd 21218	
of He		20e. Method of Disposition **ABurial 2	Removal from State	Plece of Di cemetery, o	sposition (Normatory or EMORIA	eme of other pla	ce)	Dafe 3-9-98	20c. Location -	MORE, MARYLAND		
Baltim permit. Pag Depertment Important: I	- Source	21. Signature of Funeral Service Left	T. (lose				12	06 W. NO	RTH AVE		INITY F/H	
		23a. Part1. Enter the disease, or cog shock, or heert feilure. List only	plications that caused the de-	ath. Do not	enter the mo	de of dyir	ng, such as cardia	ac or respiretory e	rest,		Approximate Intervel Between Onset and Death	
Physical Medic Examin	cal	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	(or as a con	Sequence of):	+ war	inds				
is, P.O. Box 68760, set that the deeth certificete be engineed by the attending physicial by described for recent the buries.	//Wedical	Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of):										
Box deeth cert	Iciai	Part II. Other eignificant conditions	contributing to death but not re	sulting in th	e underlying	cause di	ven in Pert I.	23b. Did	23b. Did tobacco use contribute to the cause of			
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ord requir	eted								an eutopsy med?	av	ere autopsy findings ailable prior to mpletion of cause death?	
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Vital Fidelian: The certificate	Be	25. Was case referred to medical examiner?					26. Place of De	eath (Check only o	one)			
of Vita Physician: this certific	2	1 X Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpe	tient 3 C	Ot Ot	ner: 4 ☐ Nursing	Home 5 ☐ Resi	dence 6XIOth	ner (Specif) SCENE	
On O Oil Oil Oil Oil Oil Oil Oil Oil Oil O	on:	27. Manner of Death 1 Netural 5 Pending	28e. Date of Injury (Month, Day Year)	28b. Tim Inju	ry	28c. Inju Wo			now injury occur			
Oivisi or Atten or Atten or Atten or Atten	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm,			Yes 2.₩No		Y was Street and Numb vn, Stete) 400	She ber or Rure	al Route Number, of Year Road	
e Hospital	edical C	29e. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of my kr minar: On the basis of examinand manner stated.	nowledge, de netion end/o	eeth occurre r Investigation	d at the ti	me, date and pled opinion, death occ	Baltimer ce, and due to the curred at the time,	cause(s) and middle and place,	anner as s	tated. o the ceuse(s)	
To the within 2	W	29b. Signature and title of certifier	Mas	15	29c, License number OCME				29d. Date signe			
7 2	<	30. Name end eddress of person who	completed cause of deeth (Ite	em 23a) (Ty	pe, Print)					_,		

State Registrar

Stephen S.
31. Date filed (Month, Day, Year) 111 Penn Street, Baltimore, Maryland 21201

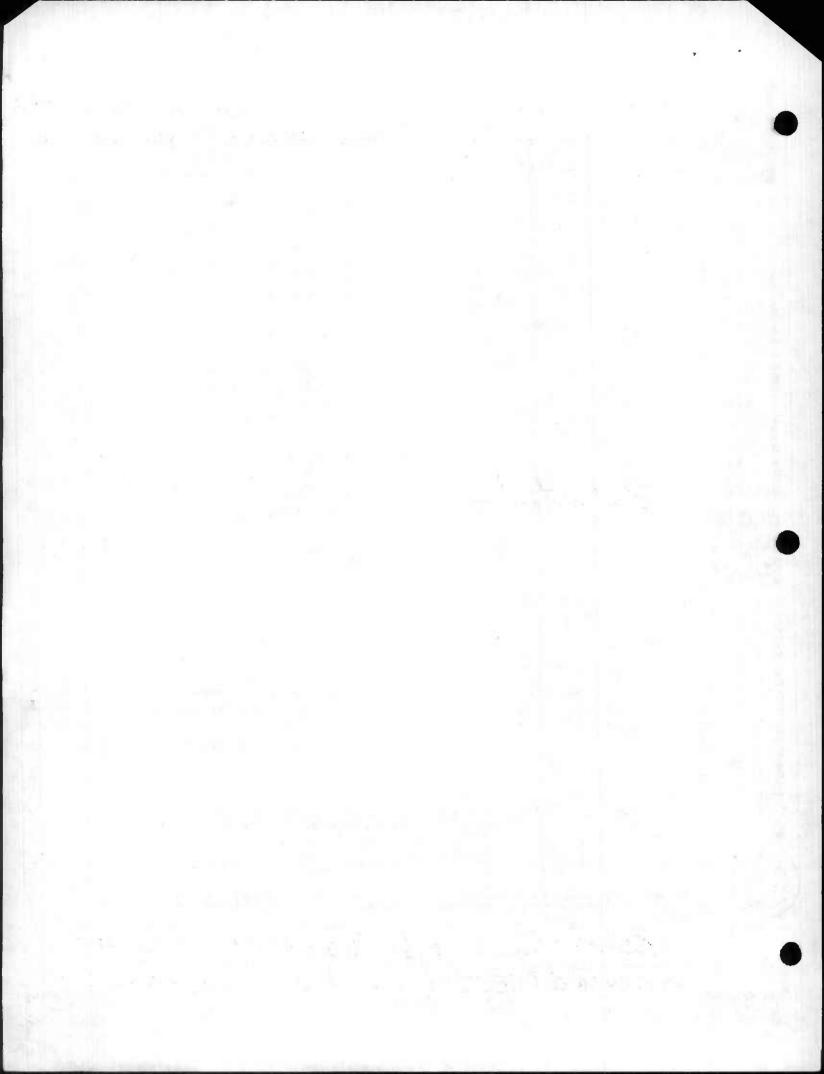


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 4 per M.D G-757 3/10/98 reb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 430 AV MARY C. BUSER 0 /Medical a. Facility Name (If not Institution, give street and number) 4 4b_City, Town, or Location of Death 4c. County of Death McGrady **Examiner** Square atonsvi If Undar 1 5. Social Security Number Yaar 8. Date of Birth (Month, Day, 6. Se If Undar 24 Hrs. Birthplace (Stata or Foreign Country) **Funeral** 7. Aga (In yrs. last birthday) Days Months 217-24-9903 Director 70 1927 TENNESSEE Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MARYLAND BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or items 23a 4 MCGRADY SQUARE 21228 U.S.A. death 12. Was Dacadent Ever In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours efter 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Spacify: WHITE by 3 ☐ Widowed 4 ☐ Divorcad "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) permit. Pages 1 and 2 should be filed wit Depertment of Health and Mental Hygiens Important: If Item 27 is marked other that any Injury or other traumatic event, the 12 CLERK A & P 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Be JAMES O. COPE ADA MARY ALDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN C. BUSER JR., HUSBAND 4 MCGRADY SQUARE, CATONSVILLE, MARYLAND 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 Donation 5 □Other (Specify) 3/5/98 BALTIMORE, MARYLAND NEW CATHEDRAL CEMETERY 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23a. Part1. Enter the disease, or shock, or heart failure. List biographic that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician ABENOCARCINOMA OF COLON /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Physician/Medical Examiner sician and bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician s the buna Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Records, ò 2 page 2 should 24b. Were eutopsy findings availabla prior to completion of causa of daeth? Completed 24a. Was an autopsy performed? 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Vital iding Physician: director, Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 PAesidenca 8 Other (Specify) 70 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA of this 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification: 28b. Time of 28c. Injury at Work? lon After 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be detarmined 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1b Certifying Physician: To tha best of my knowledga, daath occurred at the time, data and placa, and dua to tha cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and placa, and due to the cause(s) and manner stated. 29b. Signature and title of certifian 29c. License number 29d. Data signed (Month, Day, Year)

Registrar

State

30. Name and eddress of person who CHLN WURA C
31. Date filed (Month, Day, Year)
WAR 1 0 1998



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth :05 AH 4e. Facility Neme (If not) institution, give street end number, March 4b. City, Town, or Location of Death 4c. County of Death Forest Haven Nursing Home Baltimore
If Under 24 Hrs.
Hours Min. **Baltimore** If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (Stete or Foreign Country) Months Days 1□M 2X F Yrs 219-32-0513 02 N.Y. March 20, 1905 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whel Country? 213 High Falcon Road U.S.A. 21136 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorcad White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Restaurateur Food 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Joseph Josefowicz Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Robert Doarnberger / Nephew 5978 Carnel Back Lane Columbia, MD 21045 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a, Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 3-9-98 Holy Rosary Cemetery Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc. tehens 2134 Willow Spring Road Baltimore, MD 21222 Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heert feilure. List only one ceuse on each line. Approximete Interval Between Onset end Death Immediate Ceuse (Final disease or condition resulting in death) LEAK MONARY Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequença of) Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown EGURGITATION 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Tes 2 1 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examine

Physician

/Medical

Examiner

Funeral

Director

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raf, or items 23a or 28a-f shov Examiner over be notified at

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Pages 1 end 2 should be filed within 72 ho nent of Heelth end Mental Hygiene. Int: If Itam 27 is marked other than "natur Iry or other traumatic event, ma Mexical

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Baltimore, Maryland 21215-0020

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ttanding Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

sion of Vital

Examiner Physician/Medical by Completed Be 2 funeral

27. Manner of Death

edical Certification: 29a. Certifier

Natural

2 Accident

3 Suicide

4 Homicide

(Check only one)

29b. Signature and title of cartifier

sheer

State Registrar AKHANI,

5 Pending investigation

6 Could not be determined

7220 TARK 22. Registrer's Signature Na Davidson-Randala

end address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Dev Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination end/or investigetion, in my opinion, death occurred at the lime, dete and place, end due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

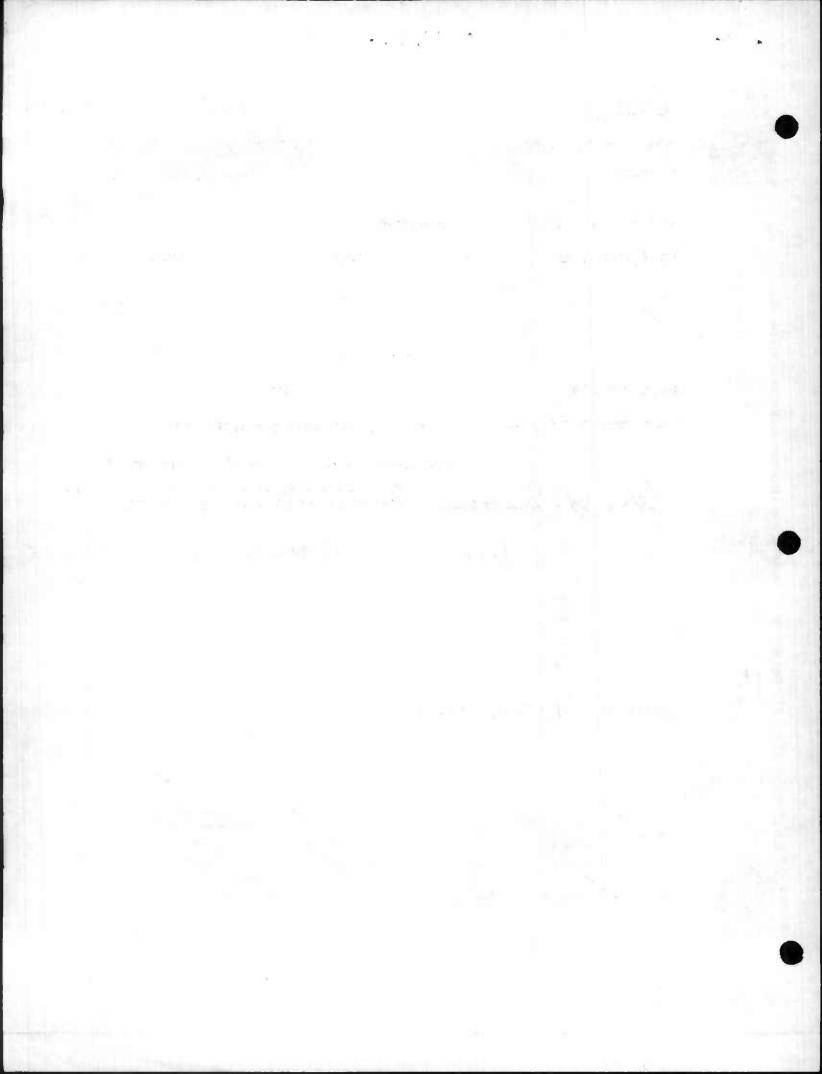
28d. Describe how Injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29d. Dete signed (Month, Dey, Year)

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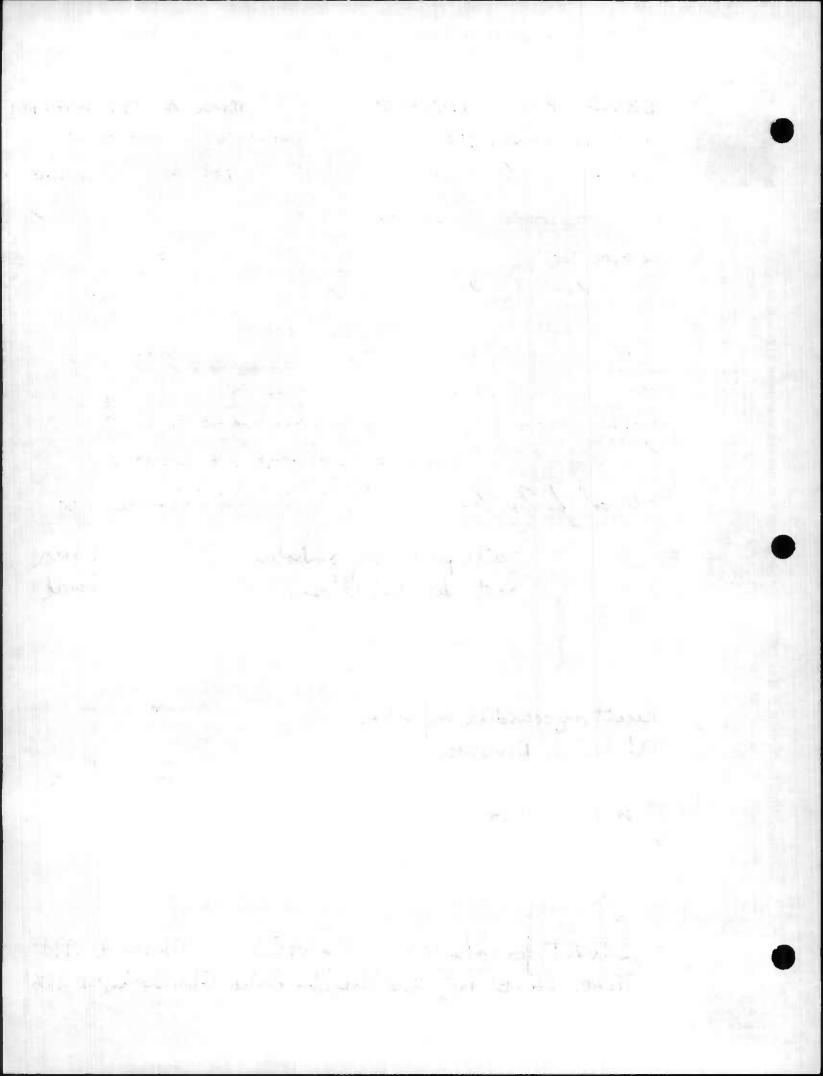


State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** DELLA BREWER 12:47 pm March /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel North Arundel General Hospital 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (Stete or Foreign Country) Funera! 1 M 2 F Deys Hours Yrs. 07/31/1919 Director 243-26-7832 78 S. Carolina Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours efter death with the Maryle nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other treumatic event, the Modical Examinar must be not lifed. the Maryler 1 Yes 2 No Director Anne Arundel Pasadena 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21122 USA 1053 Keppel Harbour Funeral 14. Race - American Indien. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Surname) John Jannie Bell Porter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) 1053 Keppel Harbour Pasadena Md. 21122 Steven Brewer/Husband 20a. Method of Disposition 20b. Ptace of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State permit, Page Department of Important: If eny injury or 4 ☐ Donation 5 ☐ Other (Specify) Oxendine Family Cemetery! 03/08 Robeson N.C 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Home 23a. Part1. Enter the disease. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. Int only one ceuse on each line. 21231 Approximate Interval Between Onset and Death **Physician** /Medicai Immediate Ceuse (Final diseese or condition resulting in death) Examiner Examiner physician end s the buriel-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Lest Due to (or es a consequence ot): requires that the death certificate be exec Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence ot): 60 65 USB signed by the e Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes -2 No 3 Probably 4 Unknown Recent my occur dial infanctor ò 24b. Were autopsy tindings available prior to 24e. Wes an autopsy Completed completion of cause of death? pege 2 hes 1 ☐ Yes - No 1 Yes ZONO certificate or Attending Physicien: director. 25. Was case reterred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes ➤ No 1 Enpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day Yeer) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending efter deeth. 1 ☐ Yes 2 ☐ No investigation 6 Coutd not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the ceuse(s) and mannar es stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mannar stated. 29a. Certifier edical 29d. Date signed (Month, Day, Year) 29b. Signature 29c. Ltcense number title of certifier mo went 30. Name and address of person who came leted cause of death (frem 23a) (Type, Print) Doeptel Drive. Glen Bornis, mo 2/06 203 JACOBS MD 31. Date tiled (Month, Dey, Year)

State Registrar



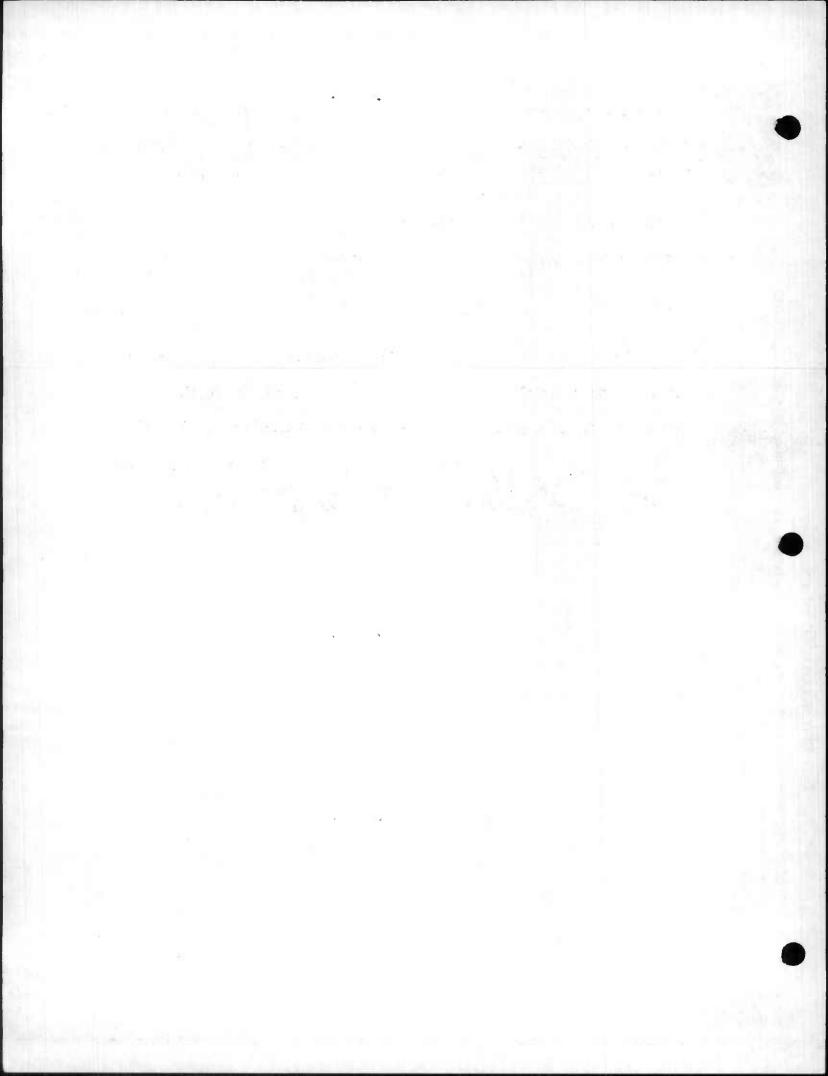
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Castle, Pauleman

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lile	Washing	ton Cour					1	Hagers	town		U	Jachi	ingto	NT)
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	23a. Part1. Ente	r the disease, or	complications th	at caused the dee	eth. Do not en	O. Bo	0x 368	3 Hanc	ock,	MD	21750	036	58	Approximet
	shock, or ne	eert failure. List	only one couse of	on each line.			rue or uying	, such as car	rdiac or i	aapiiatorj	011001,			Approximen
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by Physician/Medical	disease or condit resulting In death Sequentially list of eny, leading to cause. Enter Un Cause (Disease that Initiated ever resulting in death	e (Final tion) conditions, Immediate derlying or Injury sts	a b c	Due to (for as a consector es a consector es a consector	quenca of):):	D		23b. D	ld tobacco	o use co 2 No	ontribute t 3 Pro	to the cause obably 4 [] Vere eutopsy (valiable prior to mompletion of completion of
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o Be Completed by Physician/Medical	disease or condit resulting In death Sequentially list if eny, leading to cause. Enter Uncause (Disease that initieted ever resulting in death Part II. Other eigr	e (Final tition n) conditions, Immediate derlying or Injury nts n) Last	b c d Prescontributing to	Due to (Due to (Due to (o death but not rea	for as a consector es a consector es a consector	quence of): ::	on In Part I.	CQ.	23b. D	as an autoriormed?	o use co 2□ No opsy	pontribute t 3 Pro 24b. W au coc of	to the cause obably 4 //ere eutopsy (valiable prior to meet the cause of the caus
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DHMH 16 Rav 6/95



98-1263-510 ihm ELMER G. CUNNINGHAM

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State of Maryland / E

	2. Dete of Deeth		_		ne of	
Certificate of Death	Reg. No.	U	1	J	9	-
Department of Health and I Certificate of Death	Mental Hygiene	0	7	0	0	0

Physician	
- /Medical	
Examiner	

1. Decedent's Neme (First, Middle, Last)

Funeral Director

the Maryland item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examines must be notified at with 1 death

2 should be filed within 72 hours effection and Mental Hygiene.
Is marked other than "natural" or that Saltimore, Maryland 21215-0020 permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is in any Injury or other traun page.

Physician /Medical **Examiner**

that the death certificate be executed physician and the burial-transit 80 esn Po igned by the a page 2 s certificate has funeral

Completed

Be

10

Certification:

edical

Division of Vital Records, P.O. Box 68760. or Attanding Physician: after deat 24 hours To the Hosp within 24 hor To the Fune completely fi

Month MARCH 08, Elmer G. Cunningham 1998 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL BALTIMORE N/A To Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Months, Dey, Year) 1 Party 1 and 1 Party 1 and 1 Party 1 and 1 Party 1 and 1 Party 1 and 1 Party 1 and 1 Party 1 and 1 Party 1 and 1 Party 1 and 1 Party 1 and 1 Party 1 and 1 Party 1 and 1 Party 1 and 1 Party 1 P 5. Social Security Number 9. Birthplace (Stete or Foreign XXM 2 F 220-07-0926 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21218 USA 608 Venable Avenue Funerai Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance of Ships Ship Yard 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Matilda Donald H. Cunningham, Sr. Woppman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rita Byrd Niece 608 Venable Avenue Baltimore, Md 21211 20a. Method of Disposition

✓ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Md. Veterans' Cemetery3/10 Garrison Forest, MD 4 ☐ Doneyon 5 ☐ Other (Specify) Funeral Service Licensee 22. Name end Address of Facility Burgee-Henss Funeral Home PA 3631 Falls Road, Baltimore, Maryland
applications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, interval Between Between Page 1. 11. Enter the disease, or complick, wheart failure. List only or Immediate Ceuse (Final disease or condition resulting in deeth) Arteriosclerotic Cardiovasculas desens Due to (or es e consequence of) Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieled events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. þ

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed?

24b. Were autopsy findings aveilable prior to completion of cause of deeth?

Approximete Intervel Between Onset and Death

01:10 AM

X Yes 2 □ No

1 Yes 2 No

1 Yes 2 No

26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25.	Wes case exeminer?		to medical
	1 □\Yes	2 No	
27	Menner of	Deeth	

31. Dete filed (Month, Day, Year)

MAR 1 0 1998

1 Neturel 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide

28e. Date of Injury (Month, Dey Year) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Inpatient 2 X ER/Outpetient 3 ☐ DOA

28c. Injury et Work? 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how Injury occurred

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. 29c. License number

29b. Signeture and title of cartifier

29d. Date signed (Month, Dey, Year)

& Wright MD

OCME

MARCH 08, 1998

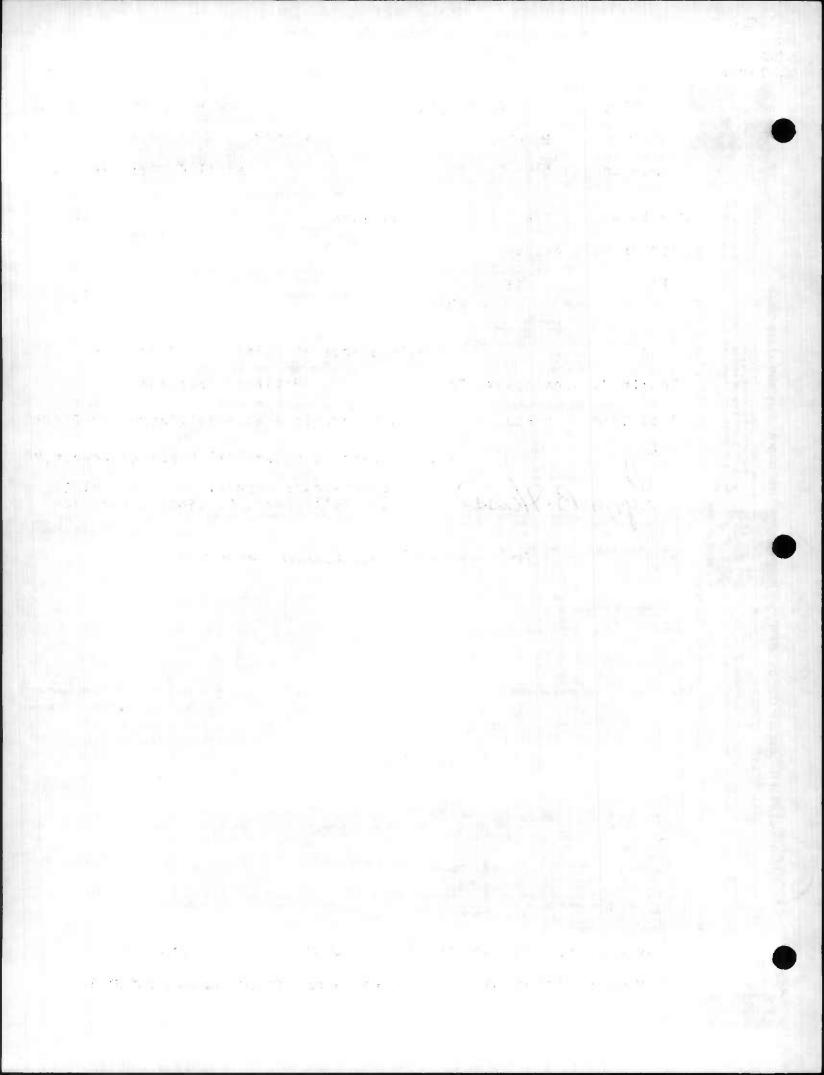
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DONALD G. WRIGHT MD

111 Penn Street, Baltimore, Maryland 21201

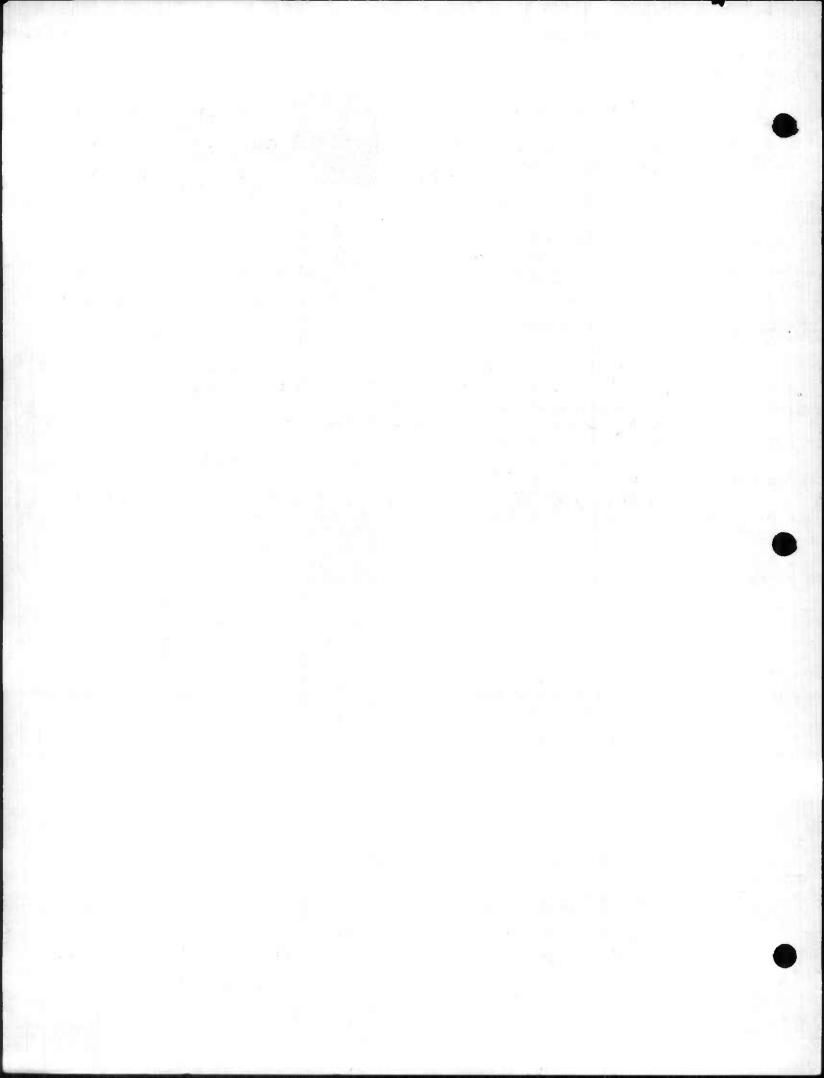
State Registrar

32. Registrar's Signature ia suidson-Randall



	State of Maryla	Certificate of Death	Reg. No.
Physician	1. Decedent's Name (First, Middle, Last) DAVID CALDWELL	2. Deta of Month	Dey Yeer
/Medical Examiner	4a. Facility Name (If not institution, giva street and number)	4b. City, Town, or Location of D	
Funeral Director	5. Sociel Security Number 24 1 24 5 166 8. Sex 10 M 2 F 7. Aga (In yr	S ADMINISTRATION BALTIMO rs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Month, Poly Min. Rebrue	Birth Dey, Year) 9. Birthplece (State or Foreign Country)
how		City, Town or Location ,	10d. inside City Limits
filed within 72 hours after death with the Maryland Hyglene. ther than "naturel", or items 23s or 28s-f show out, the Mod cal Evantine must be noutled at Some or Evantine must be some or the Mod cal Evantine must be noutled at the Mod cal Evantine must be not set of the Mod call the Mod cal	MD 10e. Street and Number	Baltimore	1 Yes 2 No
23a or	1233 Winston Ave	21239	10g. Citizen of Whet Country? W. S. A.
et, or thems 23a or 28a-f s Examiner must be nouthed by Funeral Director	11. Meritel Stetus 1 □ Never Merried 2 □ Merried 3 □ Widowed 4 □ Divorced 12. Wes Decedant Evar In Armed Forces? 1 □ Tas 2 □ No if Yes, Give Yaar or Datas:	U.S. 13. Wes Decedant of Hispanic Origin? (Specify Yas or If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Yas 2 PNo Specify:	No- 14. Rece - American Indian, Black, White, etc. Specify: Black
tal Hyglene. d other than "naturel" event, the Modical Ex event, the Modical Ex Be Completed b	15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) Collega (1-4or 5+)	16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Wag Ner	16b. Kind of Business/Industry Farmer
E S W	17. Father's Name (First, Middle, Last) Robert Caldwell, Jr.	18. Mother's Neme (First, Mid Mary	Idle, Meidan Sumeme)
0 0 2	19e. Interment's Neme/Relationship (Type, Print) Louis (aldwell	19b. Meiling Address (Street and Number or Rural Route Nu 2820 MC Comb 5 St., C	Imber, City or Town, State, Zip Code)
or other trau	20e. Method of Disposition 20b. 1 Buriei 2 Cremation 3 Removel from Steta	Piece of Disposition (Neme of Date	20c. Location - City or Town, State
Department of important: If he any injury or o snca.	4 Donetton 5 Other (Specify) 21. Signature of Funeral Service Licenses	York MEM CEM 03-09-0 22. Name and Address of Facility	E. Worth Ave
.05 6 0	23a. Part1. Entar the disease, or complications that ceused tha de shock, or heart feiture. List only one ceuse on each line.	March F. H 1101	
physician and the bundertransit and the bundertransit and street and the bundertransit a	Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause, (Disease or injury c.	diac Arrythmia (or es e consequence of): onary artery disease (or es a consequence of):	
2 2 9	resulting in deeth) Last d.	(or as a consequenca of):	
the ette	Part II. Other significant conditions contributing to death but not re	asulting in the underlying ceuse given in Pert I. 23b. [Did tobacco use contributs to the cause of death?
signed by the ettending d be detached for use of d by Physician/M	hypertension, urinary.	tract infection. 1	Yes 2 No 3 Probably 4 Unknown
s been s 2 should pleted			Ves an autopsy erformed? 24b. Were autopsy findings available prior to completion of cause of death?
page . page		1	Yes 2□No 1 Yas 2□No
certificate irector, pag	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospitei: 1 ☑ Inpatient 2	28. Piece of Deeth (Check or	
r deeth. octor: After this certific by the funeral director, filcation: To Be (27. Menner of Death 1 ☑ Neturei 5 ☐ Pending 2 ☐ Accident investigation 28e. Dete of injury (Month, Dey Year)	28b. Time of 28c. injury at 28d. Descri	lesidence 8 Other (Specify) be how injury occurred
Mer deeth. Director: After to the funeral to the f	3 Suicide 6 Could not be determined 28e. Piece of Injury - At building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc.)	home, farm, street, fectory, office 28f. Locatic City or	on (Street and Number or Rural Route Number, Town, Stete)
Figure Fi	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinend mannar stated.	nowledge, deeth occurred at the time, dete end plece, and due to netion end/or investigation, in my opinion, deeth occurred at the tir	the ceuse(s) end menner as stated. ne, dete end piece, end due to the ceuse(s)
within To the complete	29b. Signatura, and title of certifin	29c. License number	29d. Dete signed (Month, Day, Year)
	DM J MO	1310430	March 4 1998
	30. Name and address of person who completed cause of deeth (Its 22 S Greene 54 T	Baltimore, Mayland	21230
State Registrar	31. Dete filed (Month, Day, Year) MAR 1 (1998) MAR 1 (1998) MAR 1 (1998)	netura Randalla	

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #10g Per FH Film G765 11-4-98RC Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2 Data of Death 3 Time of Death Month **Physician** 12:00 NON Carel AH MUT CHAN /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, giva street and number Examiner Anne Arunde Glen Burnie Arunde North Tospita, If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) | OC'1 16,15 6. Sax 1 M 2 □ F 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Months Days CHINA 215-29-9631 Yrs. 1910 87 Usual Rasidanca of Dacedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits CROFTON 1 ¥ Yas 2 □ No ANNE ARUNDEL MD. Directo 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda HONG KONG 21114 USA 2086 INGLESIDE COURT Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No Specify: CHINESE If Yas, Giva Yaar or Datas 1 Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elementary/Secondary (0-12) Coltege (1-4or 5+) TRANSPORTATION SEAMAN 02 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Be UNKNOWN CHAN CHIN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2086 INGLESIDE COURT CROFTON, MD 21114 SAI KOON CHAN SON 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 3-9-98 BALTIMORE MD. METRO CREMATORY 21. Signature of Funaral Sanfica Licenses 22. Nama and Addrass of Facility Poatrack HARDESTY FUNERAL HOME P.A. 851 ROAD GAMBRILLS, MARYLAND 21054 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. ANNAPOLI\$ Interval Between Onset and Death Immediata Causa (Final disaasa or condition resulting in death) SEPTICEMA PNEHMONIA Examiner REBITAN, METHICHIN Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consaguanca of): Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed

Physician /Medical Examiner be executed

physician and the bunal-tran

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Certification:

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ng Physician:

Funeral

Director

r man "natural", or items 23s or 28s-f the Medical Examiner must be notifie

Maryland

Baltimore.

of Vital Records, P.O.

should be marked

Pages 1 and 2 ment of Health 1 ant: If hem 27 8

ö Department: If

> 1 Yas 2 DiNo

1 ☐ Yas 2 ☐ No

26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Tima of T- Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be daterminad 3 Sulcida

28e. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifian 🕊 Cartifying Physician: To tha bast of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. (Check only one) 2 Medical Exeminar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian

10

Month, Day,

25. Was casa refarred to medical

2 NO

axaminar?

1 Yas

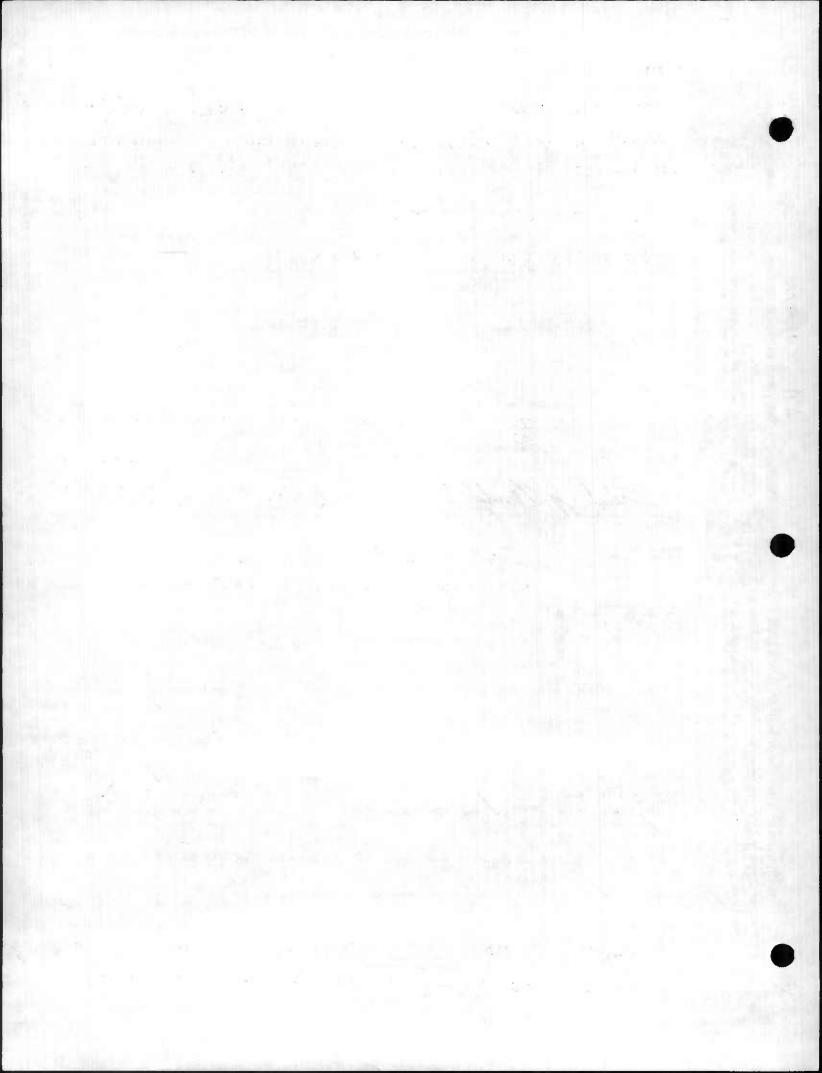
4 Homicide

MD 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hageter

Dove, Colon Brome

State Registrar

To the Vithin To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 50 p.m Willia Chapman 1998 Marie /Medical 4e. Fecility Neme (If not institution, give street engineumber, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner North Annal Hosp tu Gen Burnie ir If Under 24 Hrs. s Hours Min. Anne Arundel County If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Ye **Funeral** Deys Months 234-22-8053 Usuel Residence of Decedent 1□M 2NF 84 Yrs Director 02/26/19/14 Virginia the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hem 27 is marked other than "natural", or Hems 23s or 28s-f show other traumatic svent, the Medical Examinar must be notified at Maryland Anne Arundel Millersville 1 ☐ Yes 2 ☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 30 Rolpark Trailer Village Funeral 21108 U.S.A.

14. Race - American Indian,
Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours efter Departmant of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examina 1 Tes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried 1 ☐ Yas 2 ☐ No þ Specify: white 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) Collega (1-4or 5+) Credit Bureau Clerical 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Sumeme) Be Frank Akers Clara Cochran 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Bettie J. Gribbet Daughter 731 214th Street Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, cremetery, cremetery or other place)

Meadowridge Mem. Park March 9,1998 Baltimore, Maryland 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State
4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensed 22. Name end Address of Fecility McCully-Polyniak Funeral Home 231 Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one ceuse and line. 3204 Mountain Road Pasadena, Maryland 21122 Approximata intervel Between Onset and Deeth Physician /Medical Immediate Ceuse (Final disease or condition resulting In daeth) tuphysema yeer, Examiner Due to (or es e consequança of): Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in daath) Lest Dua to (or es e consequence of): Division of Vital Records, P.O. Box 68760 physil the Due to (or es e consequence of): The law requires that the death certificate ettanding Pert ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown 1 Yes 2 No signed t þ 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed peed page 2 has 1 Yes 1 ☐ Yes A No certificata To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifical complatally filled in by the funeral director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Mannar of Death 28b. Time of Injury 28d. Dascribe how Injury occurred 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 5 Panding Investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 3 Sulcide 28e. Plece of Injury - At homa, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicida Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and dua to the cause(s) and manner as stated.

Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et tha time, data end plece, and dua to the causa(s) end menner steted. 29a. Certifier Medical 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

30. Neme

31. Dete flied (Month, Day, Yeer)

ss of person who completed cause of daeth (Itam 23e) (Typa, Print)

· M.D

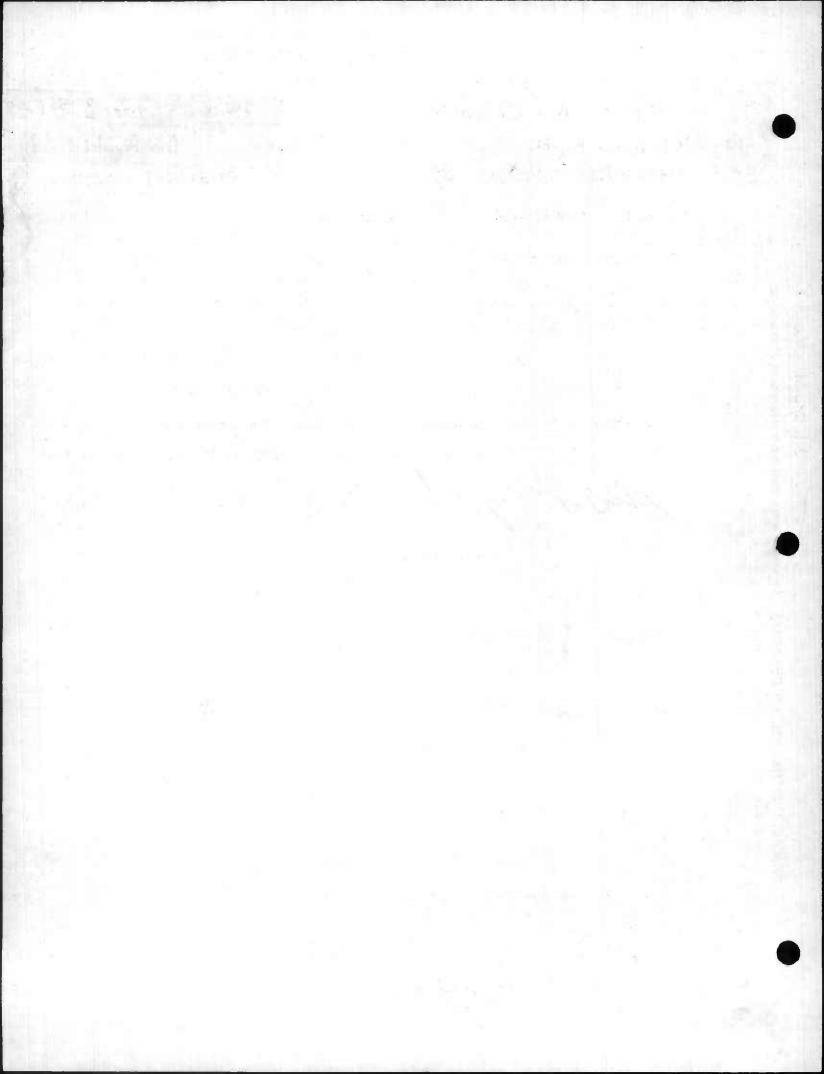
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98-1268-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. CMK State of Maryland / Department of Health and Mental Hygiene EDITH COBB Certificate of Death Items: 23a part I, 27, 28a-f per MEO G-757 3/18/98 dh 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day **Physician** Edith Elena Cobb MARCH 08, 1998 0954AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 968 STOLL STREET BALTIMORE CITY If Under 1 Year | if Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□ M 2)() F 212-50-6017 49 Yrs. **Director** Aug. 24, 1948 Pennsylvania Usual Residence of Decedent tha Maryland 10a Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Nes 2 No Md. N/A Baltimore Director 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 968 Stoll Street 21225 U.S.A. 12 should be filed within 72 hours after death vinand Mental Hygiena. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Biack, White, etc. 11 Maritai Status 1 Yes 2 No if Yes, Give Year or Dates; 1 Naver Marriad 2 Married 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Homemaker Home 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wayne J. Clyde Crystal Evelyn Howser 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Addreas (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pagas 1 and 2 sh Department of Health and Important: If Itam 27 is m any injury or other traum page. 968 Stoll Street Baltimore, Maryland 21225 Eugene C. Cobb, Jr. (Husband) Baltimore, 20b. Piace of Disposition (Name of cemetery, cremetory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crestlawn Mem. Gardens 3/12/98 Marriottsville, Maryland 22. Nama and Address of Facility
McCully-Polyniak Funeral Home 21. Signature of Funeral Servica Licensee Kevin E. Ecker 237 E. Patapsco Ave. Balto., Md. 21225

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a final factorial form. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) MULTIPLE DRUG INTOXICATION Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): attanding physician for usa as the buria Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying couse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 8 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed completion of cause of death? has 1 Yes 2 No 1 Yes 2 No certificata 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ₹ Residence 6 ☐ Other (Specify) To this unaral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: A 1 Natural 1 ☐ Yes XX No 2 Accident

Division of Vital Records. or Attanding s after death.

(Check only one)

5 Pending investigation

6)(C) Could not be determined 3 Suicide 4 Homicide

found:3/8/98

found: residence

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found:9:00M

unknown 28f. Location (Street and Number or Rural Route Number, City or Town, State) 968 Stoll Street,

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, In my opinion, death occurred et the time, date and placa, and due to the cause(s) end menner stated. 29c. License number

Baltimore, Maryland

29b. Signature and title of cartifie me

O.C.M.E.

29d. Date signed (Month, Day, Year)

MARCH 09, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. ILOREU MM MARYAMO Date filed (Month, Dey, Year) MAR 1 0 1998

111 Penn Street, Baltimore, Maryland 21201

Registrar

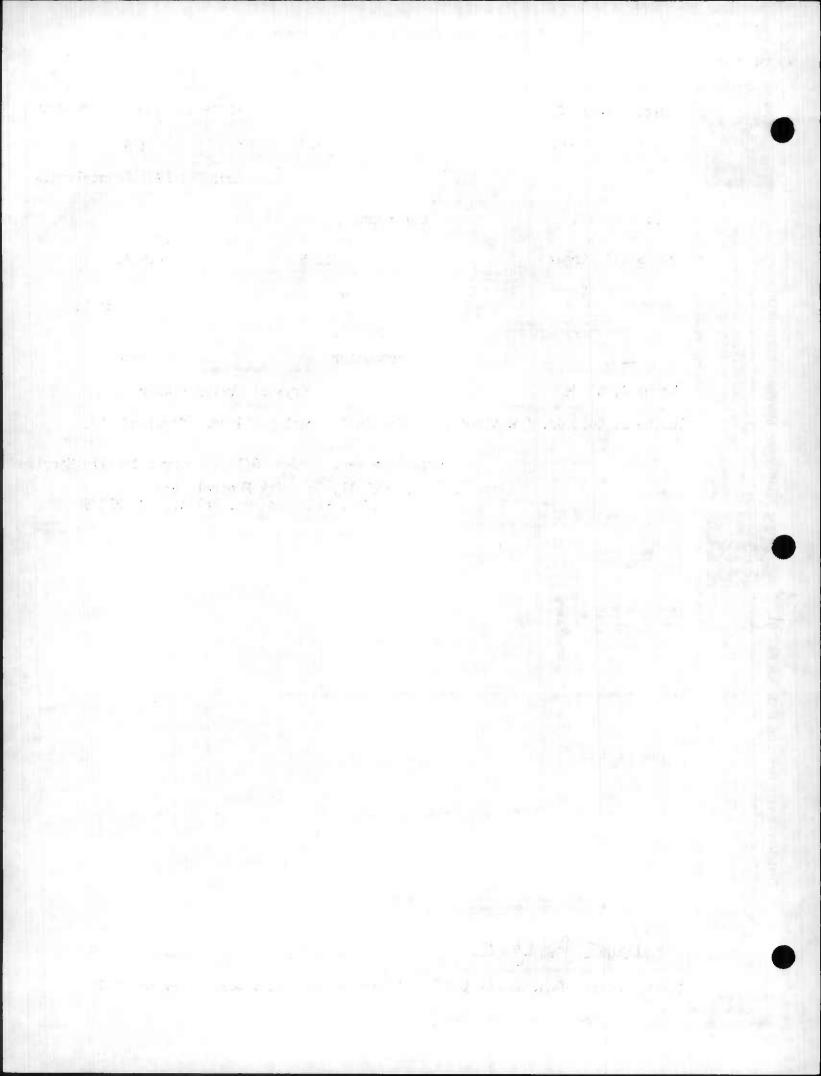
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Hospital 24 hours

within 2 the

> 32. Registrar's Signature andrewoon-Randoll



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey Pebruary 25, **Physician** George T. Douglass 1998 /Medical 4e. Fecliity Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Union Memorial Hospital | Dalcino. | Brith | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Birth | Control | Baltimore 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** XXM 20 F 214-74-4589 50 Yrs. Director Maryland Usuel Residence of Decedent the Marylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23s or 28s-f show MGYes 2□ No Director Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 3849 Quarry Avenue 21211 permit. Pages 1 and 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. US Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11 Maritel Stetus 14. Race - American Indian. Bieck, White, etc. ☐ Yes 2 No f Yes, Give 1 X Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondery (0-12) Coilege (1-4or 5+) N/A N/A N/A 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Robert L. Douglass, Sr. Ruth Bell 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Robert L. Douglass, Sr. Father 3849 Quarry Ave. Baltimore, MD 21211 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1XDBurial 2 ☐ Cremetion 3 ☐ Removei from Stete 4 □ Donetion 5 □ Other (Specify) Lake View Memorial 2/28/98 Eldersburg, MD 22. Neme end Address of Feclify Burgee-Henss Funeral Home, 3631 Falls Road Baltimore, Durgee-Henss Funeral Ho 3631 Falls Road Baltimo 23e. Peny, Enter the disease, or complication, nat coused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or hear/fullure. List only one cause on each line. Physician /Medical Immediete Caus Final disease or condition resulting in death) ASCUP minte Examiner Due to (or es e consequence of) Physician/Medical Examiner signed by the ettending physician and I be deteched for use as the burial-transit The law requires that the daath certificate be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Box 68760. Due to (or es e consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Records, þ Completed 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? has After this cartificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: director. Be 25. Wes cese referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitet: 1 ☐ Inpatient → ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No or death. octor: After this by the funeral d 27. Menner of Deeth Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Phyalclan: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, dete end piece, end due to the ceuse(s) and menner steted. 29a. Certifier Medical

Registrar

State

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30. Neme and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

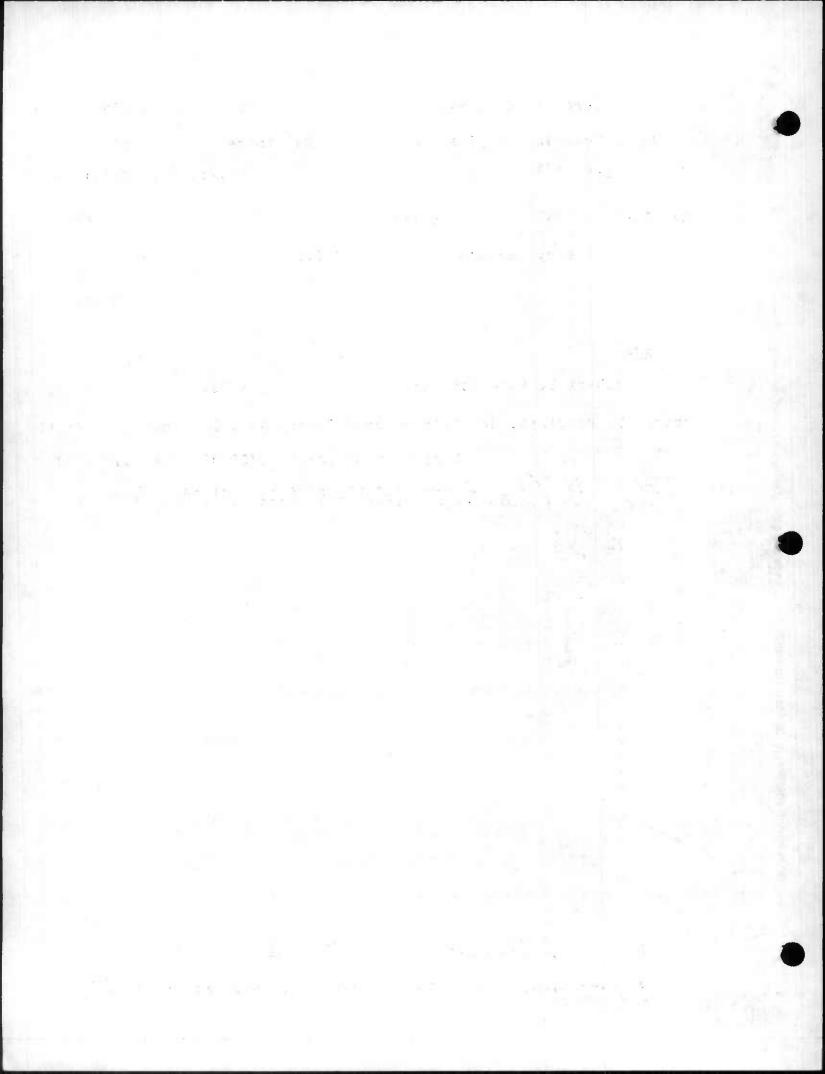
29b. Signeture and title of certifier

Richard Diamond 3730 Falls 3730 Falls Road Baltimore, Maryland 21211

D2302

29d. Dete signed (Month, Day, Year)

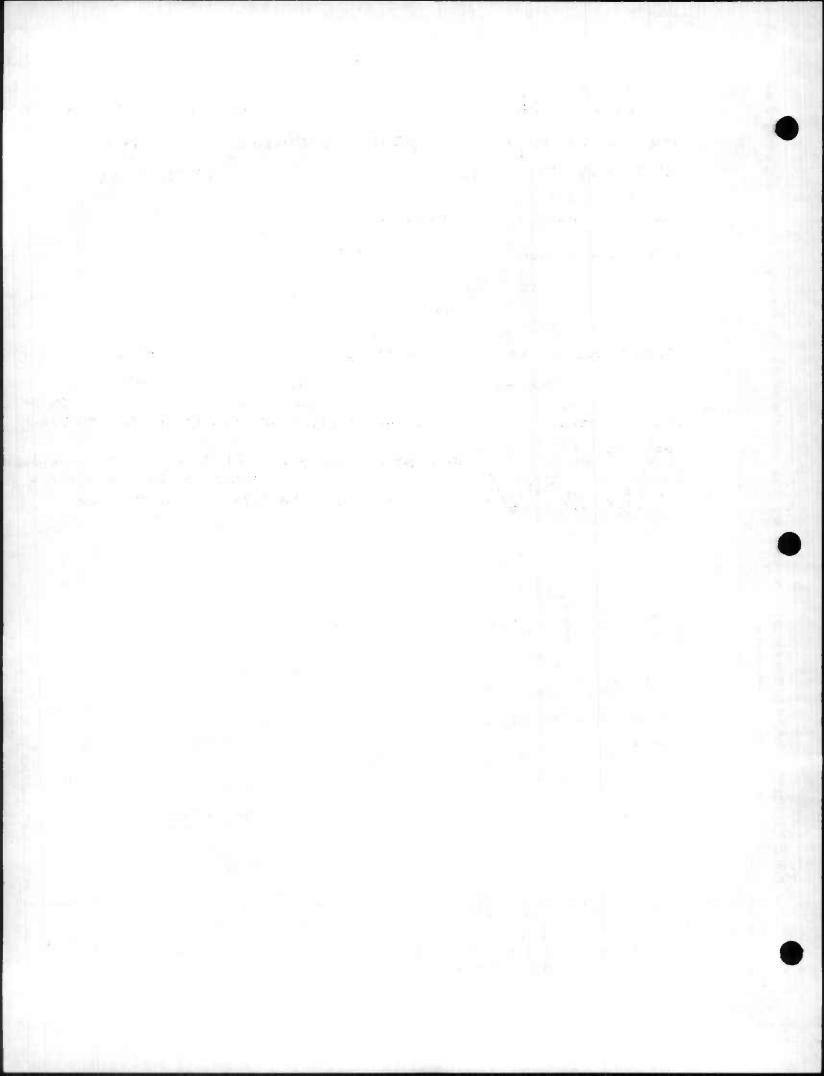
29c. License number



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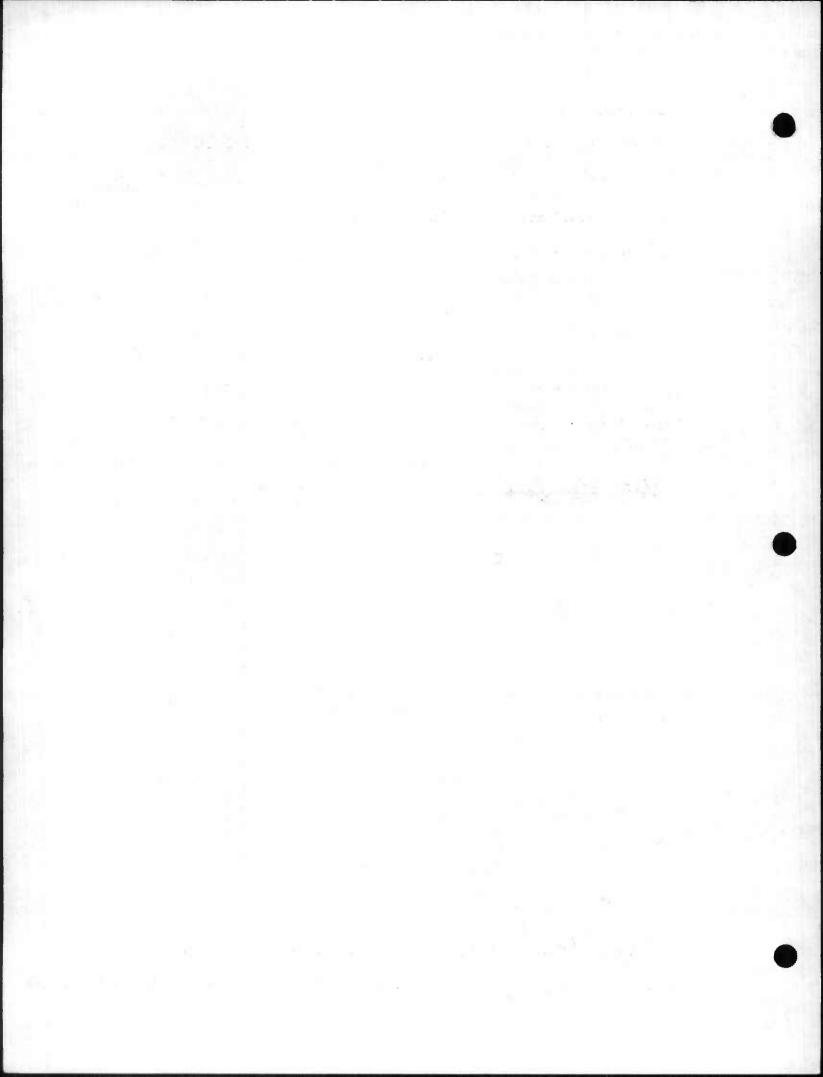
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A Ann	Certification:	1 Watural 5 Pending 2 Accident investiga		Dey roar,	M		Yes 25 No					
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3 4 5 5	ert	4 U Homicide	building,	etc. (Specify)				City or Tow	m, State)			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q

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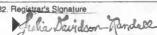


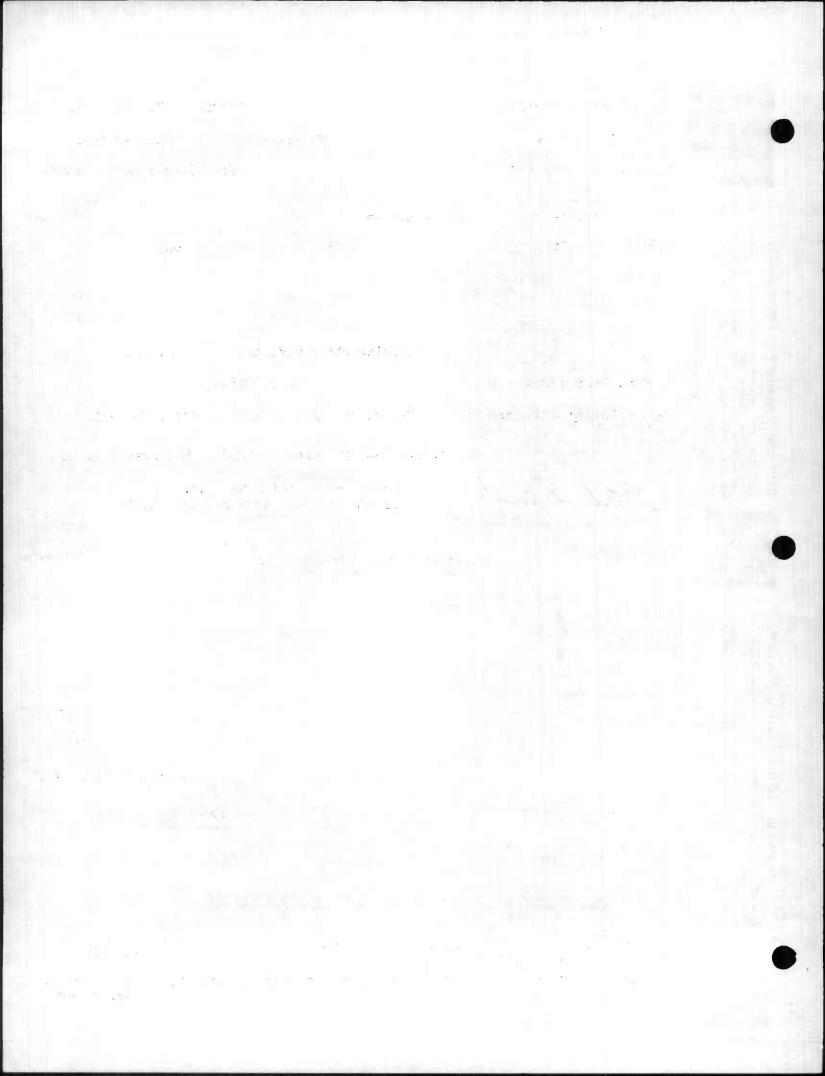
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Deeth Physician Annie Vernell Davidson February 19, 1998 10:00am /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1736 Baldwin Drive Millersville Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. July 25, 1935 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Months North Carolina 239-50-8056 62 Yrs. Director Usual Residence of Decedent r 28a-f show a notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits the Maryla MD Anne Arundel 1 ☐ Yes 2 ☑ No Millersville 100 Street and Number 1736 Baldwin Drive 10g. Citizen of What Country? 10f. Zip Code 21108 S r than "natural", or Nerse 23a or the Medical Examiner must be r USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indien 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Merried 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No White Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Officer N.S.A. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) h and Mental I permit. Pages 1 and 2 should be Department of Health and Mental reportant: If Nem 27 is marked o Raymond George Troutman Mary Cline 19a, Informant's Name/Relationship (Type, Print)
Marion Edwin - Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1736 Baldwin Drive, Millersville, MD Davidson 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baldwin Memorial Cem. 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 2/20 Millersville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Hardesty Funeral Home, P.A. alock 12 Ridgely Ave. Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Deeth **Physician** Immediate Cause (Final diseese or condition resulting in deeth) /Medicai Metastatic small bowel cancer Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) pus physician a the burlai-Box 68760 8 Physician/Medicai Due to (or as e consequenca of): 1 8 23b. Did tobacco use contribute to the cause of deeth? Part II, Other afgnificent conditions contributing to death but not resulting in the underlying cause given in Part I. o 94 3 1 Yes 2 No 3 Probably 4₺ Unknown 0 by Division of Vital Records, 24b. Were autopsy findings aveilable prior to 24e. Was en autopsy performed? Completed peen completion of cause of deeth? The law has abed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No certificate Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitel: 1□ Yes 2□No Other: 4 Nursing Home SCAResidence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 1 28a. Date of tnjury (Month, Day Year) furnaral 28d. Describe how Injury occurred 27 Manner of Death 28b. Time of 28c. Injury et Work? Certification: After 5 Pending investigation Attending 1X Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide à edicai 29a. Certifier 1 Contifying Phyalcian: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner es stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated. (Check only one) within 2 To the F 29b. Signature and title of certif 29c. License number 29d, Date signed (Month, Day, Year) D39852 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)
Howard Kaufman MD Blalock 656 Johns Hopkins Hospital 600 N Wolfe St. Balt. MD 21287 31. Date filed (Month-Day, Year) 32. Registrar's Signature

State Registra

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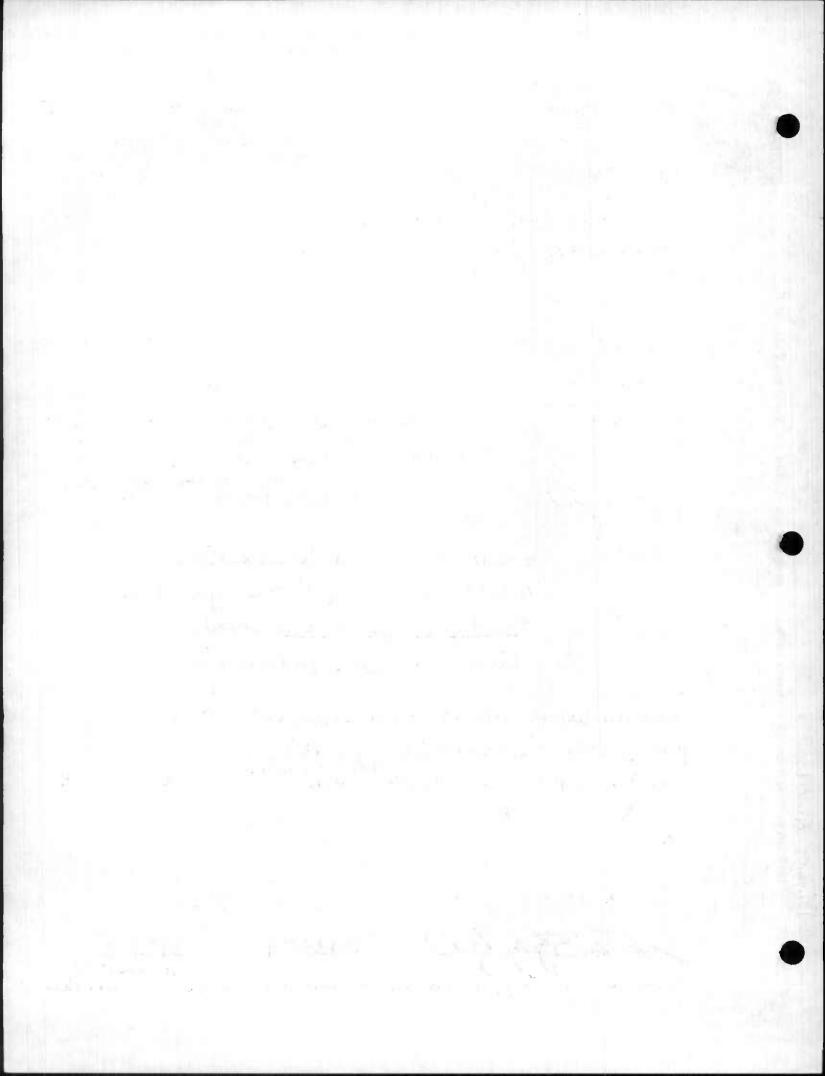




State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month Ruth Ann Dinges March 1998 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Undar 1 Yaar Months Days if Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** 1 M 2 KF 229-32-9886 Director 06-15-29 68 Virginia Usual Rasidance of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinat must be notified at 1 TYas 2 XNo Director Washington Hagerstown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 17003 Oakleigh Way #84 21740 USA Funeral 12. Was Dacedant Evar in U,S Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours efter of tent of Health and Mentel Hygiene.
nt: If Item 271s marked other than "natural; or Ite 1 ☐ Navar Marriad 2 ☐ Marriad 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Maryland 21215-0020 1 Yas & No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elemantery/Secondery (0-12) College (1-4or 5+) 11 Supervisor Custodial 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maldan Sumama) David Barber Elsie Sowers 19a. Informant's Name/Ralationship (Typa; Print) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, State, Zip Coda) Department of Health a Important: If Item 27 Is any Injury or other training. Betty Shaffer 17003 Oakleigh Way #84 Hagerstown, MD21740 Baltimore, 20b. Place of Disposition (Nama of cemetery, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Durial 2 ☐ Cramation 3 ☐ Ramoval from Stata ☐ Donation 5 ☐ Other (Spacify) Hillsboro Cemetery 3-5-98 Hillsboro, VA 22. Nama and Addrass of Facility Hall Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licenses Box 896 Purcellville, VA 20134 23a. Part1. Enter the disease of complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Intarval Batween Onsat and Death **Physician** /Medical Immediata Cause (Finel disaasa or condition rasulting in death) · electronical dissociation Examiner I respiratory distress synchrome Examiner Sequantially list conditions, if any, laeding to immediata causa. Entar Underlying Causa (Diseasa or injury that initiated avants resulting in daeth) Last Box 68760, phylococcus aureus
Due to (or as a consequence of): Physician/Medical 96 5. aureus preumonia Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown sseminated intravascular coagubby 24b. Wara sutopsy findings svailable prior to complation of ceusa of death? Completed 24a. Was an autopsy performad? 5NOCK hypokale

25. Was casa rafarrad to medical process
axaminar? Nypomagnesemia 1 Yas 2 No 1 ☐ Yas 2 No Be 26. Piaca of Death (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Certification: To 1 Yas 2 No 1 KInpatiant 2 ☐ ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Neturel
2 Accidant 1 Yes 2 No 6 Could not be 3 Suicida 28e. Piece of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mannar stated. 29a. Certifian Medical To the 29c. Licansa number 29d. Data signed (Month, Day, Year) HAGERSTOWN MD ath (Item 23a) (Type, Print) B. BRINKLEY, MD IIIL 1110 Medical Campus ed, 801 TE 226 State a Daydon-Randelle Registrar



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	Physician /Medical	Decedent's Neme (First, Middle, La John Fitzge: 4a Fecility Neme (If not institution, given)	rald E	Evans				th City Town.	2. Dete of Month MARCH or Location of De	Dey 7,	Year 1998 unty of Deeth	3. Time of Deeth 11:17P.M.
	Examiner	LANHAM ROAD & ALL	ANTOWN I	ROAD		If Under 1		SUITLAI	ND	PRIN	NCE GEO	
	Funeral Director		Sex MAZM 2□ F	7. Age (In yrs. Ia 33	Yrs.		Days		in. (Month.	Birth Dey, Year) 18-65	NC NC	plece (State or Foreign ntry)
Marviand	and show	10e. Stete 10b. County VA • NA			Town or Lo							10d. Inside City Limits 1 ☐ Yes 😤 ☐ No
th with the	or items 23s or 28s-f show what must be notified at Funeral Director	10e. Street and Number 2637 Arlingt	on Driv	7 e		1	30		8	10g. Citizen	ntry?	
5-0020 72 hours efter deeth with the Mandand	al', or itsms 234 Examiner must by Funeral	11. Meritei Stetus X ⊠ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed For	1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes Year or Detes:				lispa <i>n</i> lc Origin? an, Mexican, Pu Specify:	(Specify Yes or lerto Rican, etc.)		Race - Ameri Bleck, White, ecify: B1	
21215-0020 d within 72 hours ef		15. Decedent's E (Specify only highest gr	ade completed) College (1		16a. Decedent's Usuel Occupation (Give kind of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done done done do						of Business/Ir	
land 2	d of H	17. Father's Name (First, Middle, Las-	3yrs D O O O O O O O O O O O O	5 •	CI	erk		18. Mother's Nell	Neme (First, Mid	-		overnmen ha
e, Maryland	Health and Memory for the trsumat	19e. Informent's Name/Reletionship Donald evans 20e. Method of Disposition	(Type, Print)	20b. Ple	316	East	3r	d. Ave	Rurel Route Nu	arlott		28431
Baltimore,	Department of Important: If Its any injury or o	1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Special Signature of Emeral Service Lice	(fy)	Stete	metery, crem	Bran	er ple	Cem.	03-14-	98 Fa	irblu	iff, Nc.
PI	hysician /Medical xaminer	23 Pert1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Finel disease or condition resulting in deeth)	nplications that con one cause on ea	alte	1	er the mode		ch FH ng, such es cere	1101 E		n Ave	Approximate Interval Between Onset end Death
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State Registrar

31. Dete filed (Month, Dey, Year)

29b. Signeture end title of certifier

THEODORE M.Kmg

32. Registrer's Signeture

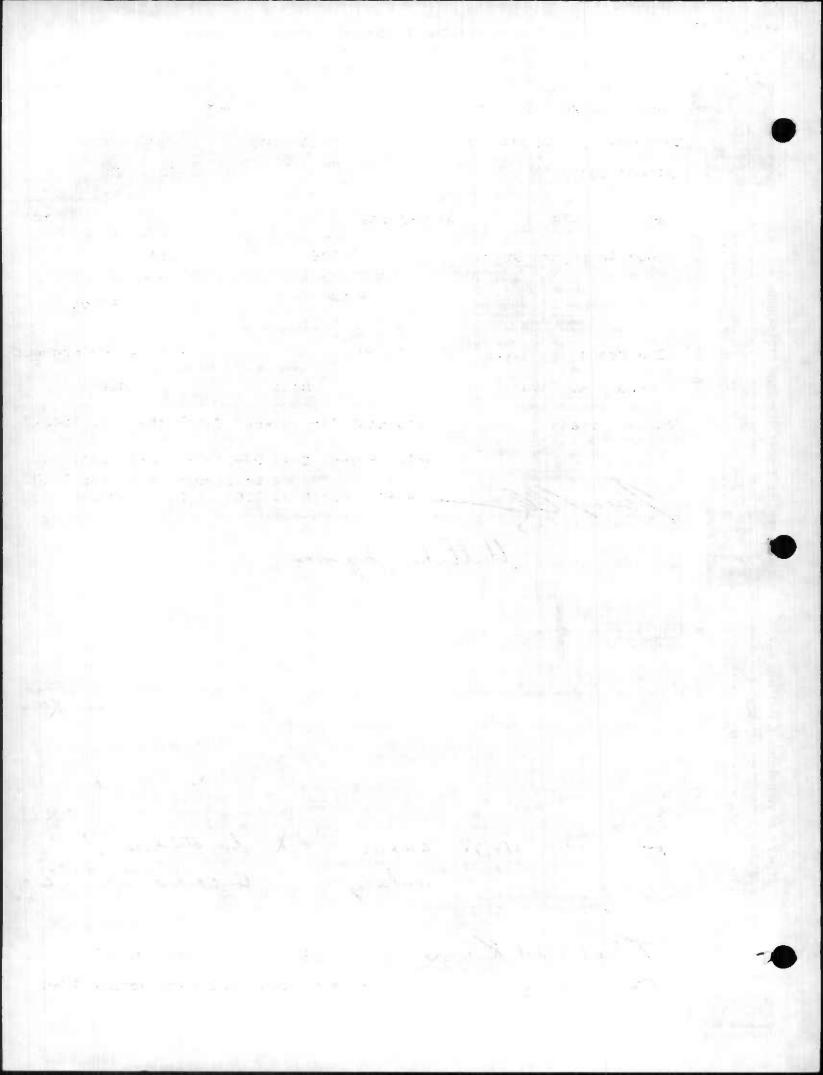
30. Neme and eddress of person who completed cause of volth (Item 23e) (Type, Print)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

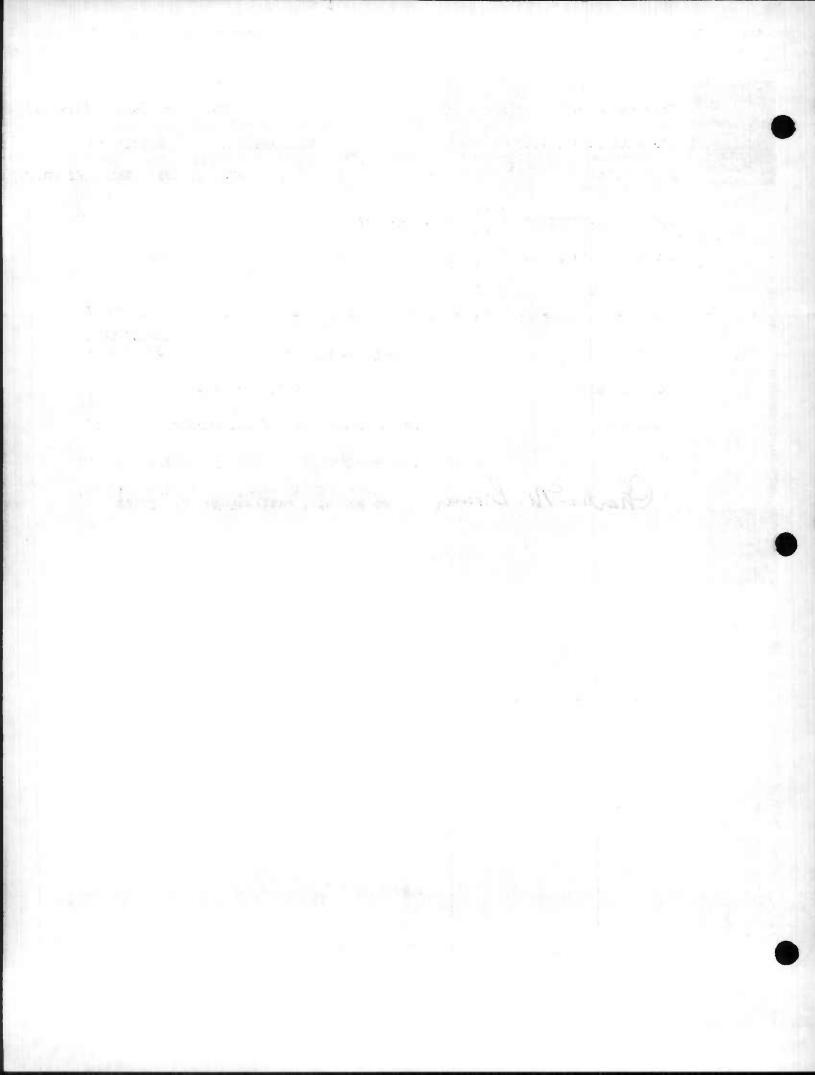
MARCH 8,1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiana

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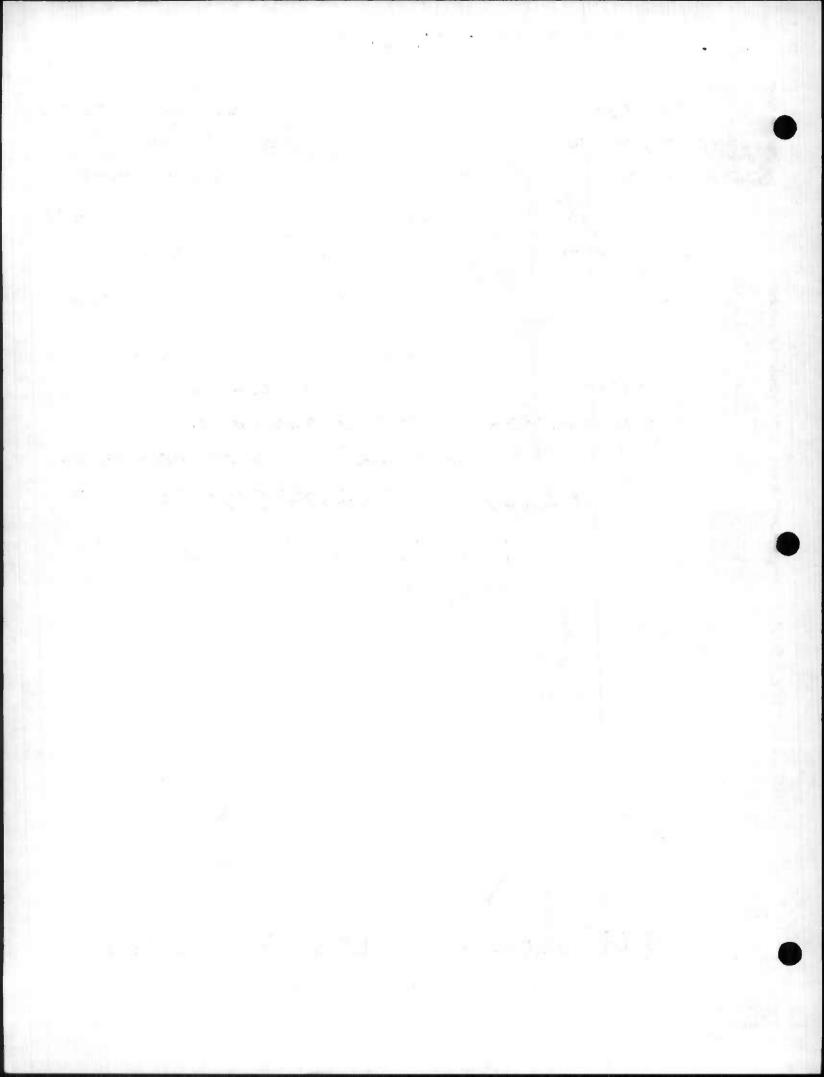
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Q R 7 1, 1 1

	_										Reg. No.			
Dhysisian	_	Decedent's Name (First	, Middle, La	ast)						2. Date of De Month	eath Day		Year 3.	Time of Deeth
Physician /Medical	-	Eleni D. Ergas									5, 1998			0 P.M.
Examiner	- 10	te. Facility Name (If not in	stitution, gi	ve street and number	r)			4	b. City, Town, o	or Location of Dea	th 4c. Co	unty o	f Death	
		224 S. Chester	Stree	t					Baltimon (N	/A		
uneral	1	5. Social Security Number			ige (In yrs. lest) If Under 1 Months	1 Year Deys	If Under 24 H Hours Mi		rth ev. Year)		9. Birthplace (State or Foreig
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or selection	1	1 d.	N/A		Balti	more								Yes 2 N
be notified	-	10e. Street end Number	1911				10f. Zip (Code			10a. Citizer	of Wi	hat Country?	
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	2	224 S. Chester	Street				,	21231			Green		,	
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em 27 i		Catherine Alaf	assos ,	/ Daughter						timore, M	1. 21231			
r oth	2	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cren		Domesial from State	20b. Place ceme	a of Disposer, cre	osition (Name	e of her plac	e)	Date	20c. Locat	ion - C	City or Town, S	state
		4 Donation 5 O					metery			3-11,1998	Baltin	pre	, Md. 21	224
Important: If any injury or once.		21. Signature of Funeral S	ervica Lica	nsee			2. Name and			1				
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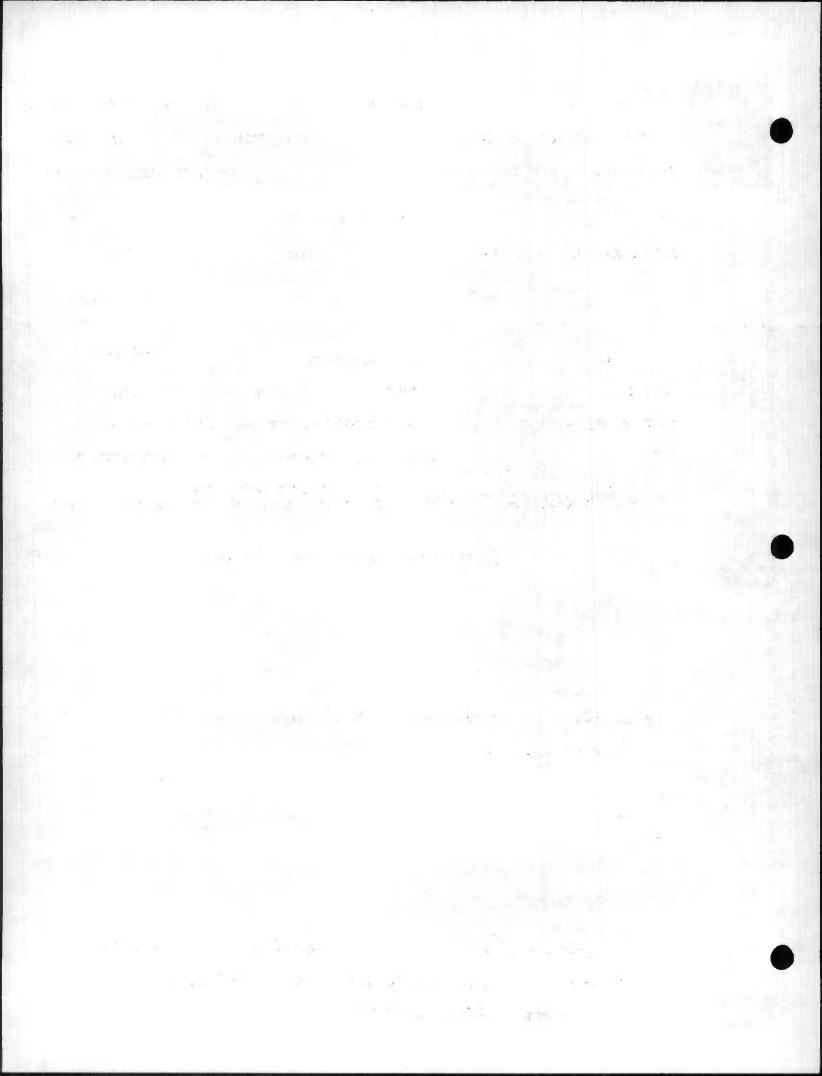
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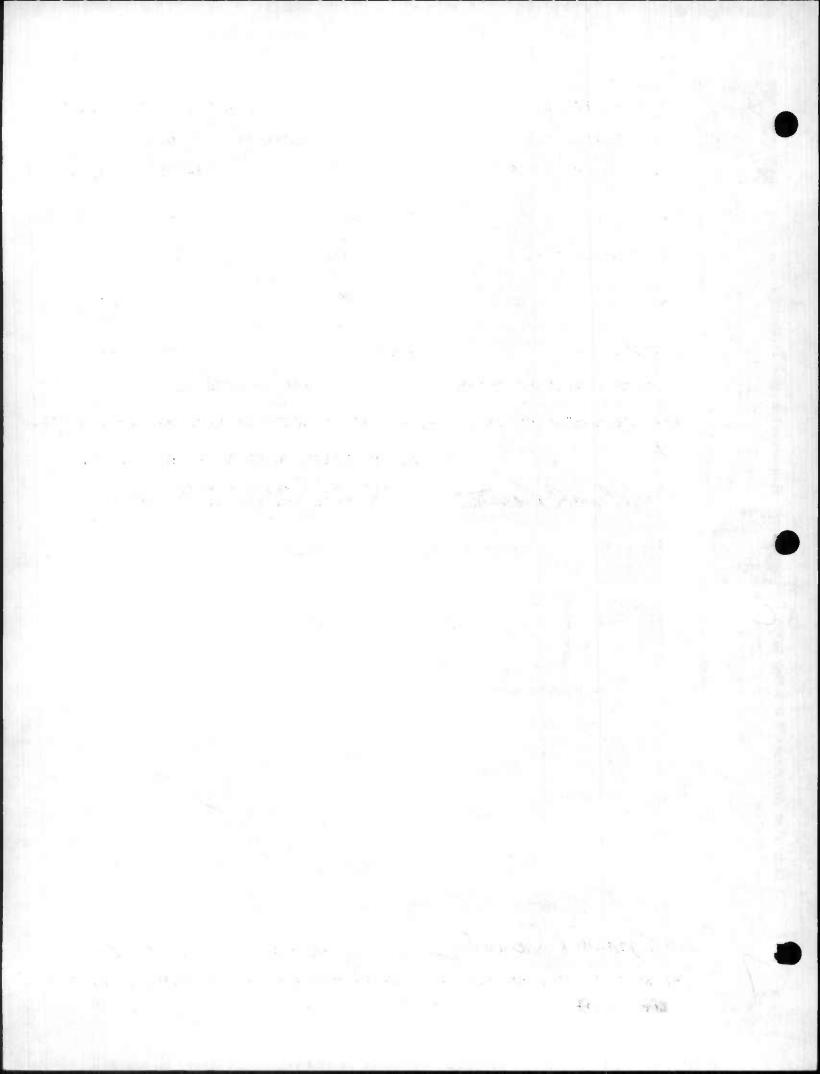
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		D NURSING				REISTE	RSTOWN			IMORE
uneral irector	5. Social Sacurity Number 216–22–3798	6. Sax 1□ M 2√		yrs. last birthday, Yrs.	If Undar 1 Y Months D	aar If Under 24 Hrs ays Hours Min		^{Yaar)} 191	9. Birthpla Countr 1 MA	RYLAND
	Usual Rasidanca of Deceda 10a. Stata 10b. Co		10c.	City, Town or Le	ocation				100	d. Insida City Limits
ector	MD N/				LTIMORE					1 Yas 2 No
2 5	10e. Street and Number 3315 CLARKS	LA., APT.	1-E		10f. Zip Co	^{da} 21215	10	og. Citizen of V	Whet Countr	À3
Examinat must by Funeral	11. Marital Status 1 Never Marriad 2 2 Widowed 4 Dive	Married 1 []	Decedant Ever I ed Forcas? Yes 2 No as, Giva r or Dates:	n U,S. 13.	Was Decedant If Yas, specify	of Hispanlc Origin? (Cuban, Maxican, Pual No Specify:	Specify Yes or No- to Rican, etc.)		e - America ck, Whita, at	
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	17. Fathar'a Nema (First, Mi	ddle, Last)			HOMEMA		ma (First, Middla, M			
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r is marks traumatic To	t9a. Informant's Neme/Rala	ationship (Type, Print	1)	19b. Mail	ng Addrass (S	treet and Number or R	lural Routa Number,			
If Item 2 or other	IRVIN FRIEDM 20a. Method of Disposition 1 Buriel 2 □ Crame	ition 3 Removel		b. Place of Disp	osition (Nama matory or otha	r place)		PALTI		vn, Stata
Important: any injury ance.	4 Donation 5 Oth 21. Signatura of Funaral Sa		DIMM	2	2. Nama and A	ddrass of Fecility VINSON & BE	ROS., INC.			
rsician edical aminer	23a. Pert1. Enter tha disaes shock, or haert failure. Immediata Causa (Final disaese or condition rasulting in death)	sa, or complications List only ona causa a.	a on each lina.	laath. Do not an	tar tha moda o	CISTERSTOWN dying, such es cardia	e or raspiratory arra	nst,		21208 Approximate finterval Between Onsat end Daath
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igned by the ettending be deteched for use a by Physician/M	Part II. Other significant co				indarlying caus	lema				the cause of death? ably 4 - Unknown
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page 2							1 □ Ya	s 2 No	10	Yas 2 No
s certificate director, pag To Be Co	25. Was casa refarred to me examiner?						ath (Check only on	Θ)		
this ral di	1 ☐ Yes 2 ₹ No 27. Mannar of Death 1 ★ Natural 5 ☐ P	anding 28a.	1 ☐ Inpatiant Date of Injury (Month, Day Yea			Other: 4 M Nursing Injury at Work? 1 Yes 2 No	Homa 5 Rasida 28d. Describe ho			
Director: A I in by the fi ertificati	3 Suicida 6 □ C	vastigation ould not be stermined 28e.	Place of Injury - / building, atc. (Sp	At home, farm, st ecify)			28f. Location (Street and Number or Rural Routa Nu City or Town, Stata)			
To the Funeral Director. After to completaly lilled in by the funeral Medical Certification:		dicat Examiner: On				he time, date and plac my opinion, death occ				
comp Me	29b. Signatura and titla of co		/			censa number		9d. Data signe		lay, Year)
6	30. Nama end addrass of pe	IIII	cause of death	Itam 23a) (Tyne	Print)	00470,		3/5	1185	
2	SH.M	ALINUW	3635	ad 6	ent Na	MAIL	mt 21	200		
State	31. Data filed (Month, Day,	Year)	32. Registrar's S	ignatura						

Registrar



					Ce	rtificate c	of Death		Reg. No.			
Physician		Decedent's Name (First, Middle, Last)					Dete of Death Month Day Year				3. Time of Death	
edical	H.	RUTH H. FOGLE							07 199	98	8:05 am	
miner	L	4e. Facility Neme (If not institution, give street end number) 802 VENABLE AVE					Ab. City, Town, or Location of Death BALTIMORE N/A					
ral tor	213-38-8544 1 M 2 F 91 Yrs. Months Days							8. Date of Birt (Month, Da 09-05	8. Date of Birth Month, Day, Yeer) 09-05-1906 9. Birthplace (State or Foreig Country) MARYLAND			
		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit										
rector	MD. N/A BALTIMORE									1 No Yes 2 No		
Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What								What Country	y?		
rai		802 VENABLE AVE. 212										
by Funeral	•	1 Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Yeer or Dates:	?		Was Decedent of Yes, specify C	of Hispanic Origin? uben, Mexicen, Pue lo Specify:	(Specify Yes or No- into Ricen, etc.)	14. Red Bla Specifi	ce - Americer ck, White, et	c.	
Completed		15. Decedent's Edu (Specify only highest gred) Elementery/Secondery (0-12) 12YRS •	cetion e completed) College (1-4or	5+)	16a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired) HOUSEWIFE					Kind of Business/Industry		
BeC	1	7. Fether's Neme (First, Middle, Last)				2011222	18. Mother's N	ame (First, Middle,			11	
To Be C		HAMLET DUVALL HODGKINS EVA RO						OBBINS	DBBINS McVEY			
		19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)										
To	2	EVA MAE GUSTAF 20e. Method of Disposition 1 Surial 2 Cremation 3 DR		20b.	Plece of Dispo cemetery, cren	sition (Neme of netory or other p	piece)	Date	20c. Location -	City or Town	n, Stete	
Important: h any Injury o once.	-	4 Donetton 5 Other (Specify) ST. JOHNS HUNTINGDON03/11/98 BALTO., MD.										
	1	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility HENRY W. JENKINS & SONS CO.										
	+	4905 YORK RD. BALTO., MD. 21212.										
n		23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death										
al er	1	Immediate Ceuse (Final disease or condition resulting In death) ### CANDIAL INPARTICAL a.								5	Juz	
ne.				Due to (or as a conseq	uence or):						
Examiner	000	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying										
ician/Medical Examir	t	ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as e consequence of):										
clan	L											
y Physician	P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i.							23b. Did tobacco use contribute to the cause of d			
by Pi								1 🗆 1	res 2□ No	3 Probal	bly 4 Unknow	
pleted	-	***						24a. Was e		avalla	autopsy findings able prior to oletion of cause ath?	
Com								1 🗆 Y	es 214 No	101	res 2□ No	
o Be	2	Hospital: Other							ath (Check only one) Home 5 Ø Aesidence 6 □ Other (Specify)			
n: T	2	7. Manner of Deeth	28a. Date of Inju		28b. Time of	28c. In		28d. Describe h				
atio		1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(WOIIII, De	y reary			☐ Yes 2☐ No					
completely filled in by the funer		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)						er or Rural F	Route Number,		
	2	29a. Certifler (Check only one) 12 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Me	2	29b. Signature and title of certifier 29c. License number 101373						2	29d. Date signed (Month, Dey, Yeer)			
	3	0. Neme and address of person who cor	mpleted ceuse of c	leath (Iten	n 23a) (Type. I	Print)			3/9/	10		
		FRANCIS X. CARMODY M.D. 7505 OSLER DRIVE SUITE 212 TOWSON, MD. 21204										

State Registrar A. Radistrar's Signature

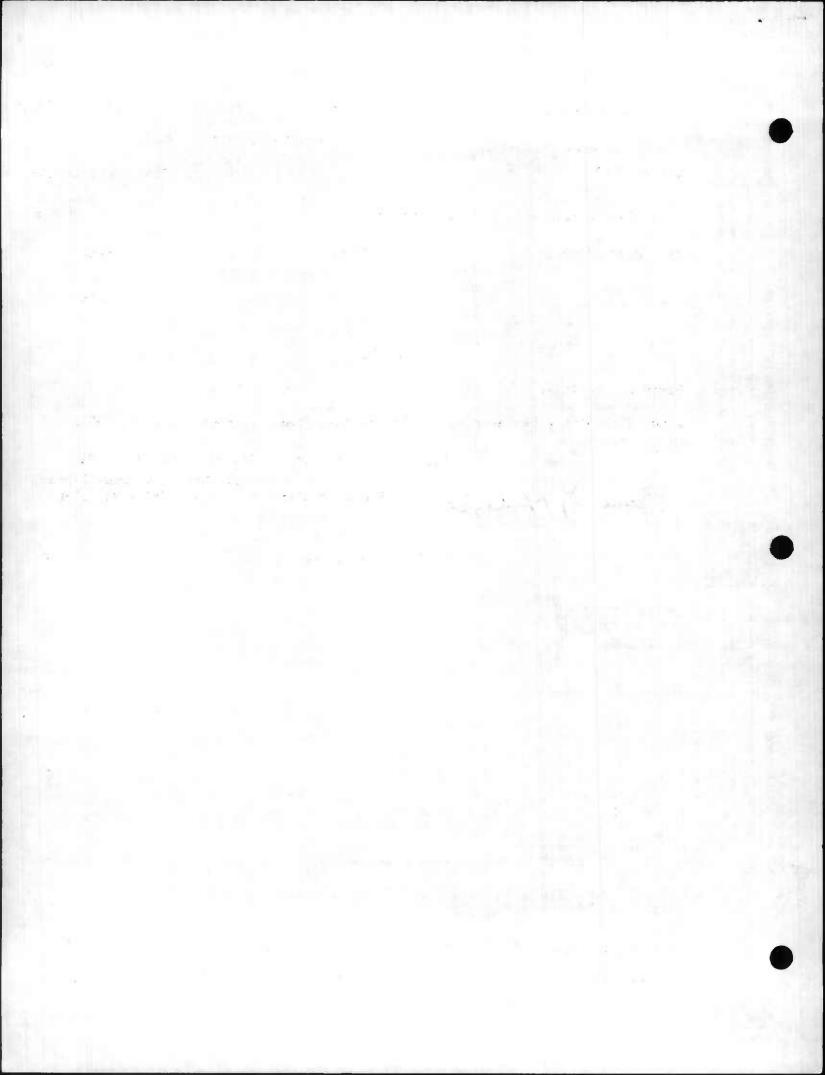


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State of Maryland / Department of Health and Mental Hygiene 9 9 71, 15

					Cei	rtificat	e of	Death			Reg. No.	0 0	1410	
	1. Decedent's N	eme (First, Middle, Li	ast)						:			Veera	3. Time of Death	
Physician	L	-AUREL				FOL	LK		17	MARCH	4	1998	8:33AM	
/Medical Examiner	4a Facility Nam	e (If not Institution, gi	ve street and numbe	or)				4b. City, Tov	wn, or Loc	ation of Deeth	4c. Co	inty of Death		
LAMITME	mile Tox		- HOCDIMA]	BALTIM	ORE C	CITY	N/A			
	5. Social Securit	INS HOPKIN by Number 6.	S HUSPITAL	L. Age (In yrs. las	Ab. City, Town, or Location of Death Ac. County of Death Ac.	place (State or Fore								
uneral irector	166-20-0		1□M 280F	71		Months	Days	Hours	Min.	(Month, De	y, Year) 1926	Cou	ntry)	
COLO	Usual Residence			/1						Julie /	, 1720	LCIII	15 y I vani I a	
=	10a. State	10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limi	
P Jo	Virginia	a Fairfax		Alexa	andri	a							1 ☐ Yes 2 🔯 N	
ecto	10e. Street and	Number				101 7in	Code	_	_		10g Citizen	of What Cou	ntn/2	
from 238 of 284-18 from must be nothed Funeral Director		nden Stree												
	11. Marital Statu		12. Was Deceder Armed Forces	nt Ever in U,S. s?	13.	Was Deced f Yes, spec	dent of I cify Cub	Hispenic Orig an, Mexican	gin? (Spec , Puerto R	ify Yes or No ican, etc.)	- 14.			
		larried 2 Married	1 ☐ Yes 2¾ If Yes, Give	3 No		1 ☐ Yes	2KNo	Specify:			Spi	ecity: Whit	White	
l by	3:CXWidowe	d 4 Divorced	4 ☐ Divorced Year or Dates:									,		
Completed	//	15. Decedent's E pecify only highest gr			16a. Dece	dent's Usua	al Occu	pation	of working	7	16b. Kind o	of Business/Ir	ndustry	
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10	12				Homem	aker					At Ho	me		
BeC	17. Father's Nar	me (First, Middle, Las	t)					18. Mothe	r's Neme	(First, Middle, Maiden Surname)				
To	Nevin B	. Greninge	r	June He						kman				
-		s Name/Relationship			19b. Mailin	na Address	S (Stree	t end Numbe	or Rural	Route Numb	er. City or To	wn, Stete, Zi	p Code)	
	1	arkenton /												
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ouce.	4 Donatio	on 5 Other (Speci	ify)	Mt.										
ouce.	21. Signature of	Funeral Servica Lica	insee		22	2. Name er	nd Addr	ess of Facility	y Eve	rly-Wh	eatley	Funer	al Home	
8	Mrs.	~ 1	R. 01											
	23a, Pani, Ent	er the disease, or con	nolications that caus	ed the death.	Do not ent	er the mod	de of dv	ing, such as	cardiac or	respiretory e	rrest.		Approximete	
	shock, or heart failure. List only one cause on each line.											i	Interval Between Onset and Death	
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Completed												a	vallable prior to ompletion of cause	
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Ö										1)	Yes 2 N	lo 1	☐ Yes 200 No	
Be (eferred to medical						26. Place	of Death	(Check only one)				
10	examiner?	No	Hospital:	itient 2 El	R/Outpetier	nt 3 DC	DA O	her: 4 Nu	irsing Hom	e 5 Resi	dence 6	Other (Spec	ify)	
	27. Manner of D	eath	28a. Dete of In	njury 2	8b. Time o								-	
Certification:	1 Naturel 2 Accider	5 Pending investigation	(Month, E	Jey Year)	Injury				No					
Ca	3 ☐ Suicide	6 ☐ Could not i	De George of I	Injury - At hom	e farm st	eet fector	v office		2	28f. Location (Street and Number or Rural Route Number,				
E	4 ☐ Homicide 28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify)													
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Item#7,8,16b per FH G 7573 State of Maryland / Department of Health and Mental Hygiene 8 3/10/98 recertificate of Death Item: 7 per F.H.G. 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Death **Physician** 3:35 PM Mildred Marie Foster March 1928 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) **Examiner** North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yeer) 9. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Days Hours Min. 1 M 2 F Yrs. 64 64 63 Nov. 215-30-0768 28, 1934 Maryland Director Usuel Residence of Decedant the Meryland 10e. State 10b. County 10c. City, Town or Location 10d. Insida City Limits ral', or Items 23s or 28s-f show Examiner must be notified at Maryland Anne Arundel Pasadena 1 ☐ Yes 2 KNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 196 9th Street 21122 U.S.A. Funeral 72 hours after deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ■ No 14. Rece - American Indian, 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 ☐ Married "natural", or 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 7 is marked other than "natur traumatic event, the Medical 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. Elamantary/Secondary (0-12) Southway Bowling Collega (1-4or 5+) 0 Cashier Lanes 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Peges 1 and 2 should be end Mental Bernard Foster Evelyn Hill 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Haalth Item 27 Linda Sears (Sister) 196 9th Street, Pasadena, Maryland 21122 other 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 5 Department of important: If It any injury or o phose. 1 ■ Buriel 2 □ Cremetion 3 □ Removel from State Glen Haven Mem Park 3-5-98 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home 21. Signeture of Funeral Service Licent 3204 Mountain Road, Pasadena, Maryland 21122 w Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) was **Examiner** Due to (or es e consequence of): Examiner en ce photo party physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Dua to (or as a consequence of): Physician/Medical Due to (or es e consequence of): thet tha daath certificete attanding for use as ed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed I Division of Vital Records, by The law requires 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? bleen si 24a. Was en eutopsy Completed his certificate has but director, page 2 s 1 Yes 2 No or Attending Physician: 25. Was cesa rafarrad to medical exeminer? Be 26. Place of Deeth (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Mannar of Daath 28d. Describe how injury occurred 28b. Time of 28e. Deta of Injury (Month, Day Year) 28c. Injury et Work? Certification: 1 Natural 2 Accidant 5 Pending 1 Yes 2 No death. investigation after death Director: A d in by tha f 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di completaly filled in Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the ceuse(s) end menner as stated.

Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) end menner stated. 29e. Certifier edicai 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number 40525 and eddress of person who completed cause of deeth (Item 23e) (Type, Print) udolf litanii W- D . North 1a Registrar's Signature 31. Date filed (Month, Day, Year) State

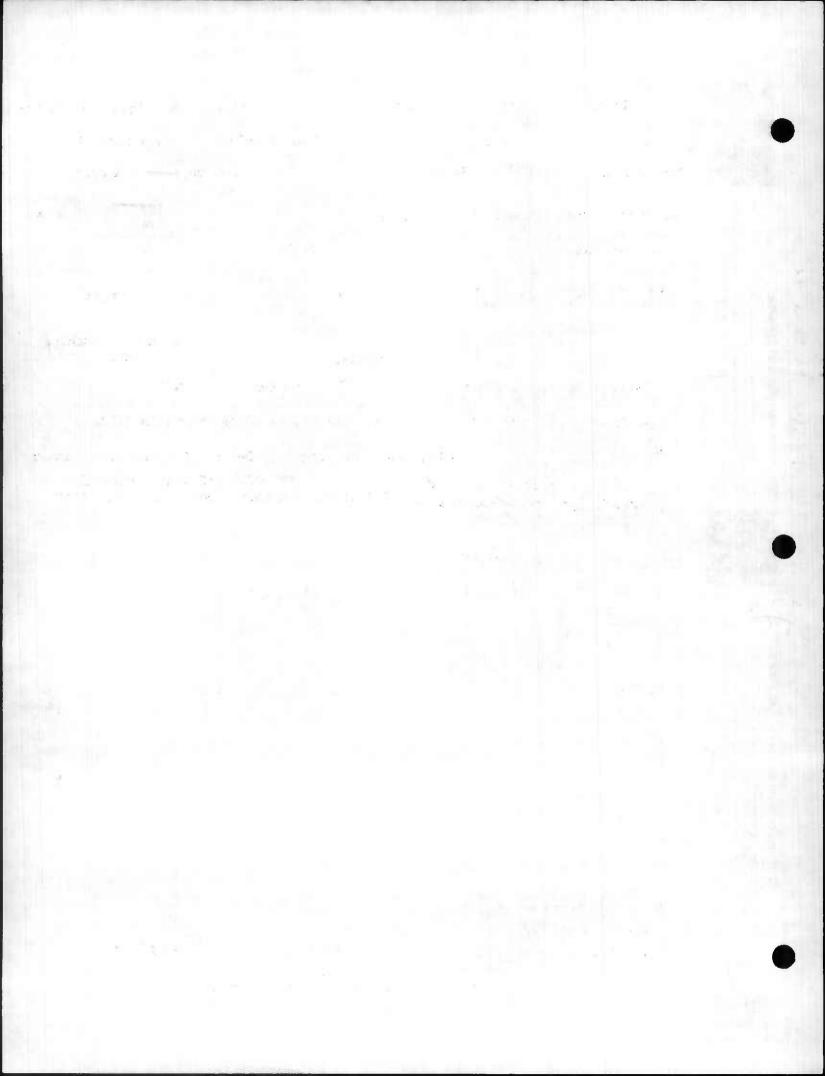
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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3 Time of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** MARCH 5, 1998 GOLDBERG ROSE 7:45am /Medical 4b. City. Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** 9 POMONA SOUTH, APT. 2 BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Days Hours 1□ M 25 F YES 89 Director 215-05-0695 FEB. 26, 1909 RUSSIA Usuel Residence of Dacedani with the Meryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo MARYLAND BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Streef and Number 10f. Zip Code 9 POMONA SOUTH, APT. 2 21208 USA Funeral death 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No ff Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: ff Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed will Department of Health and Mentel Hygiens Important: If itam 27 is marked other the page any injury or other traumatic event, Impage. 12 17. Father's Neme (First, Middle, Last) 18. Mother'a Name (First, Middla, Maidan Sumeme) MORRIS SASS LENA **POLIACK** 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) 19a. Informant'a Name/Ralationship (Type, Print) MR. HARRY GOLDBERG (HUSBAND) 9 POMONA SOUTH, APT. 2 BALTIMORE, MD 21208 20b. Pleca of Disposition (Neme of cametery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removel from State ARLINGTON-CHIZUK AMUNO 3-6-1998 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208 sase, or complications the deused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in. List only one cause on each line. Partt Ente Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) 20 years atheroscientic cardiovascular discase Examiner Dua to (or es a consequance of): Physician/Medical Examiner Saquentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events attending physician end for use es the buriel-tren Due to (or as a consequenca of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): resulting in death) Lest The law requires that the death Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributs to the cause of death? he 1 Yss 2 No 3 Probably 4 Unknown signed by diabetes mellitus þ 24b. Were autopsy findings eveilable prior to completion of cause of daeth? 24a. Was an eutopsy performed? Completed peen has 2 X No certificate Physician: 25. Was casa rafarred to madicel exeminer? Be 26. Placa of Daath (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Director: After this 28d. Describe how Injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: or Attending 1 Natural 5 Pending investigation 1 Tas 2 No 2 Accident death. 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - Af home, farm, street, factory, offica building, etc. (Specify) 4 I Homicida efter within 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the besis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a, Certifian plately (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier March 5, 1998 10 30. Nama and addrass of person who completed cause of daath (Itam 23a) (Type, Print) ZI CROSSROADS DR. #400 OWINGS MILLS, MD TAMARA SOBEL, MI)

State Registrar 31. Dete filed (Month, Dey, Year)
MAR 1 0 1998



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 1. Decedent's Nama /First Middle Last) 2. Data of Deeth 3. Tima of Deeth **Physician** /Medical 4b. City Town, or Location of Deeth not institution, giva street and number) 4c. County of Death Examiner NursingCenter

last birthday) | thundar 1 Yaar |

Months Days N/A tan 2-01-599 If Undar 24 Hrs. 6. Sax Birthplace (State or Foreign Country) **Funeral** Days 1□M 210F Hours Director Virginia Usual Rasidence of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: If team 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examine must be notified as 10d. Insida City Limits 1 ☐ Yas 2 No Director Maryland Baltimore Glenmont 10f. Zip Coda 10e. Street and Numbar 10g. Citizan of What Country? 1213 St. Andrews Way 21239 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - American Indian, Biack, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2X No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: p 3 Widowed 4 □ Divorced White Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) Coltege (1-4or 5+) 12 years Retail Restaurant Manager 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meidan Sumama) Be William Glendyle 0'Donnell 9 Mary Jane Pitts 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Coda) Barbara Gehring (daughter) 1213 St. Andrews Way Baltimore, Maryland 21239 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 3-10-98 Green Mount Crematory Baltimore, Maryland 22. Nama and Addrass of Facility
Mitchell-Wiedefeld Home, Inc. 21. Signatura of Funarai Sarvice Licensas 23a. Part1. Entar tha disease, of complications that caused tha deeth. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilura. List only one cause on each line. en 6500 York Road Baltimore, Maryland 21212 Approximete Intarval Batw **Physician** /Medical Immediata Causa (Final disaesa or condition resulting in deeth) Examiner neumonia attending physicien and for use as the burlat-transit Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disease or injury thet Initiated avants rasulting In daath) Last bua to (or as e consequence of): Q & P I V Q (10)

Due to (ovas a consequance of): Division of Vital Records, P.O. Box 68760, -10 Gr -Physician/Medical 5tro 1989 signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 □ Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No ementia by 24b. Wara autopsy findings availabla prior to complation of causa of death? 24e. Wes en autopsy performed? Completed gastroparesis. certificate 1 Yas 200 No 1 Yas 22 No tal or Attending Physician: T s after death. si Director: Attentis certificat ed in by the Uneral director, pa 25. Was cese referred to madical examinar? 26. Place of Daath (Check only ona) Hospital: 1 Yas 25 No Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Dascribe how Injury occurred Certification Naturai 2 Accidant 5 Panding 1 ☐ Yas 2 ☐ No investigation 6 Could not be datermined 3 Suicida 28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 | Homicida To the Hospital or within 24 hours eff To the Funeral Di completely filled in To Cartifying Physician: To the best of my knowledga, daath occurred at tha time, date and place, end dua to tha causa(s) and manner ss stated.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at tha time, data and place, and dua to the causa(s) and manner steted. 29e. Cartifiar edical 29b. Signatura and titia of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 4650 30. Nama and addrass of person who complated ceuse of death (Item 23e) (Type, Print)

5601 Loch Raven Blvd. Baltimore, Maryland 21239

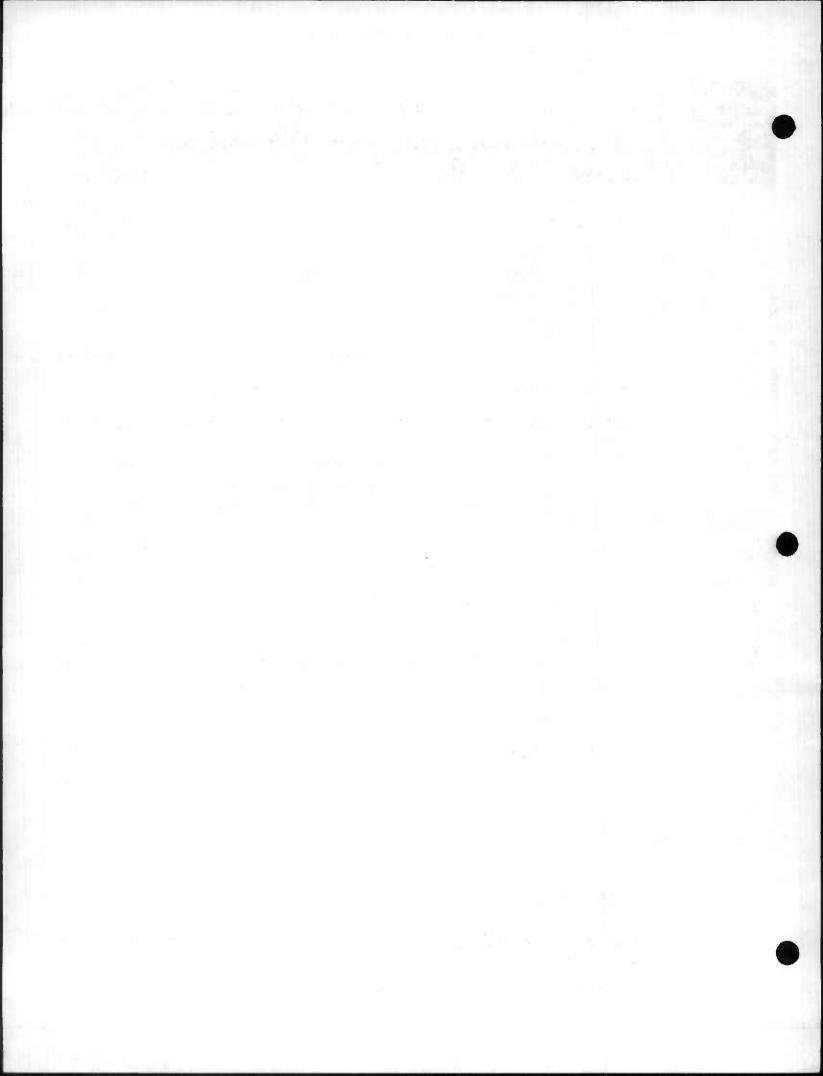
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wha dayldoon of

State Registrar Jeffrey Cool, M.D.

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31. Data filad (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 Item: 7 per F.H. G-757 3/10/98 reb Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth CRACE Month FRANCIS 9.15 ATG Harch 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth TOWSON Elde HIHOREL If Undar 1 Yaar Months Days ff Under 24 Hrs. Birthpieca (Stata or Foreign Country) Hours 216.18.3935 Usual Residence of Decedent 73 74Yrs 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No 10e. Street end Numbai 10f. Zip Code 10g. Citizen of What Country? ENTER 12. Wes Decedant Evar in U,S. Armed Forces? 1 M Yas 2 □ No If Yes, Give Yeer or Dates: W W / 11. Marltai Stetus Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) Race - American Indian, Biack, Whita, etc. 1 Never Merried 2 ☐ Married Specify: Wh 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilaga (1-4or 5+) assembly line CURS 17. Fether's Name (First, Middle, Last) TRACE 19e. Informent's Neme/Relationship (Type, Print) 19b. Melling Addrass (Straat end Number or Rural Route Number, City or Town, Stete, Zip Code) SKVEN DUITE100 20b. Pleca of Disposition (Neme of cometery, cremetory or other plece) 20e. Method of Disposition Data 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Spacify) Signature of Funeral Servica Licensee ZOROWSKII 1201 complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, only one cause on aech lina. 23a. Pert1. Enter the disease, or com-shock, or heart feilure. List only Approximata interval Betw Onset end Deeth Immediate Ceuse (Final disaesa or condition resulting in daath) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24a. Wes en autopsy performed?

Physician /Medical Examiner

physician end the burial-trensit

been signed by the ettending should be deteched for use as

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To the Hospital provided in 24 hours off To the Funeral Discompletely filled in

funeral director.

Division of Vital

Examiner

Department of Important: If

Physician

/Medical

10a. Stata

Director

Funeral

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Examiner

Funeral

Director

nit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland amment of Health and Mentle Ibygiene.
orient: If term 27 is marked other than "natural", or items 23a or 28a-f ehow injury or other traumatic event, I'm Medical Exeminal must be nother than

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Disaase or Injury that initiated events resulting in deeth) Lest

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. þ 24b. Were eutopsy findings eveilebla prior to completion of cause of daath? Completed 25. Was case referred to medical axeminer? Be 26. Piece of Daath (Chack only ona) Othar: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of fnjury (Month, Dey Year) Certification: 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturei 2 Accident 5 Pending invastigetion 1 ☐ Yas 2 ☐ No 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edical

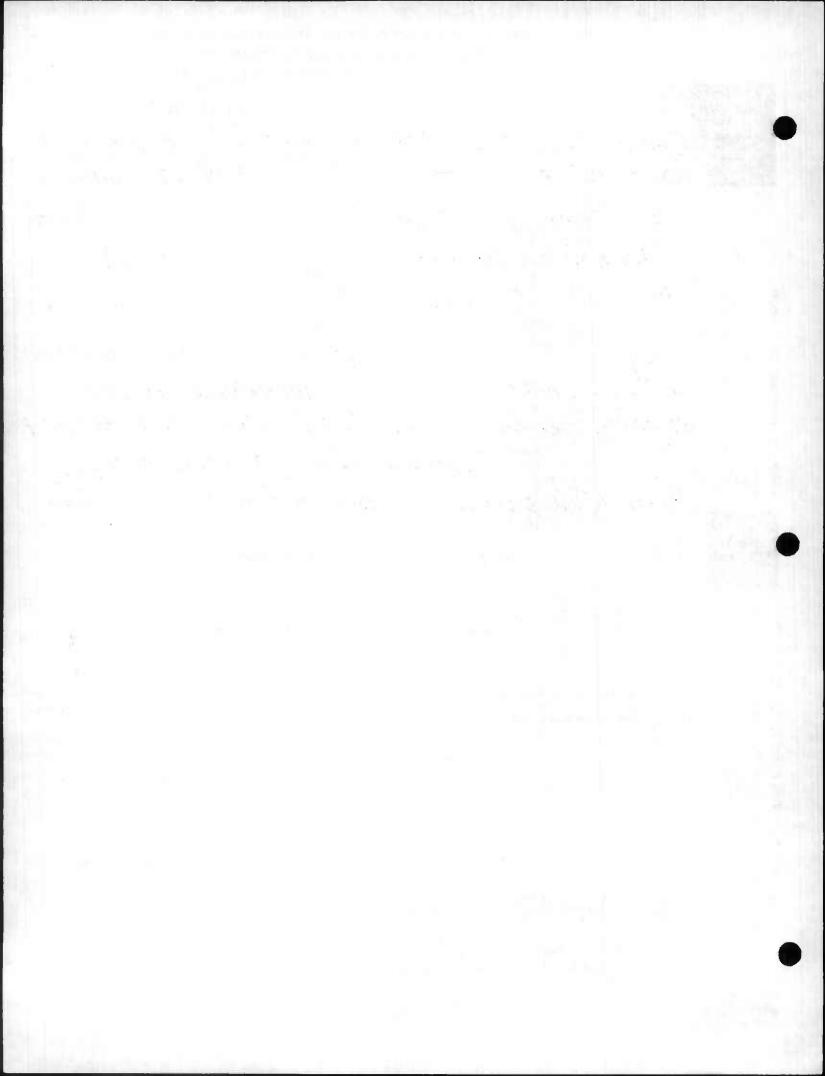
29a. Certifier (Check only one) 1 Cartifying Physician: To the bast of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Madfcal Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et tha time, date end pleca, end due to the causa(s) and menner steted. 29d. Data signed (Month, Day, Year) Hareh 9th 9 29c. License number D 30661 29b. Signeture end title of certifiar

TRIPURANENI 30. Nema end addrass of person who completed cause of deeth (item 23e) (Type, Print) S(REESH Rd. Baltimole, Emgle 8720 Hd -31. Dete flied (Month, Dey, Year)

State Registrar 32 Popularer's Signatura ha Daydon

0 1998



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 2. Date of Death 1 Decedent's Name (First Middle Last) Month **Physician** 7.10 AM Elmer L.Grim March /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner GLEN BURNE North Arundel Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 27, 1907 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2□ F Months Deys Yrs. 90 Director 213-03-4332 Virginia Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2√ No Pasadena Anne Arundel Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21122 7614 Beach Drive deeth , Funeral 14. Raca - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Merried 25 Married White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede complated) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry permit. Peges 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "n. any injury or other traumatic avent, the Medions. Elemantary/Secondary (0-12) Collega (1-4or 5+) Cotton Mill N/A Supervisor 8 17. Fether's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Minnie Ashwood Harvey Grim 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Raletionship (Type, Print) 7612 Beach Drive Pasadena, Maryland 21122 Gloria Lavinder Daughter 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Druidridge Cemetery March 11,1998 Baltimore, Maryland 22. Name end Address of Fecility McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland 21122 23a Fert1. Entar the diseasa, or complications the caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximeta Intervel Between Onset end Deeth **Physician** 2 days Immediate Ceuse (Final diseasa or condition rasulting in deeth) /Medical Pneumonia Examiner Due to (or es a consequence of): Physiclan/Medical Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or es e consequence of) USB signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Atrial Librillation þ 24b. Were eutopsy findinga eveltable prior to completion of cause of death? Anemia 24e. Was en eutopsy performed? Completed hes 1 ☐ Yes 2 No 1 Yes 2 No or Attanding Physician: 25. Was casa raferred to medical exeminer? 26. Pleca of Deeth (Check only ona) Be Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Realdenca 6 Other (Specify) To

1 Yes 2 No 27 Menner of Death

5 Pending Investigation 6 Could not be detarmined 28a. Date of Injury (Month, Day Yaar) 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28b. Tima of

28c. Injury et Work? 1 Yes 2 No 28d. Describe how injury occurred

(Check only one)

1 Naturel

2 Accident

3 ☐ Suicide

4 Homicida

12 Certifying Physician: To the best of my knowledge, death occurred et the tima, date end pleca, end due to the causa(s) and menner as atated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Sheri/ 8 (455 cm

29c. License number 051400 29d. Dete signed (Month, Dey, Year) March, 8, 1998

28f. Location (Streat and Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sherib E1955al North arundal Hospital 301 Haspital Drive Glan Burnie MD

Registrar

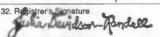
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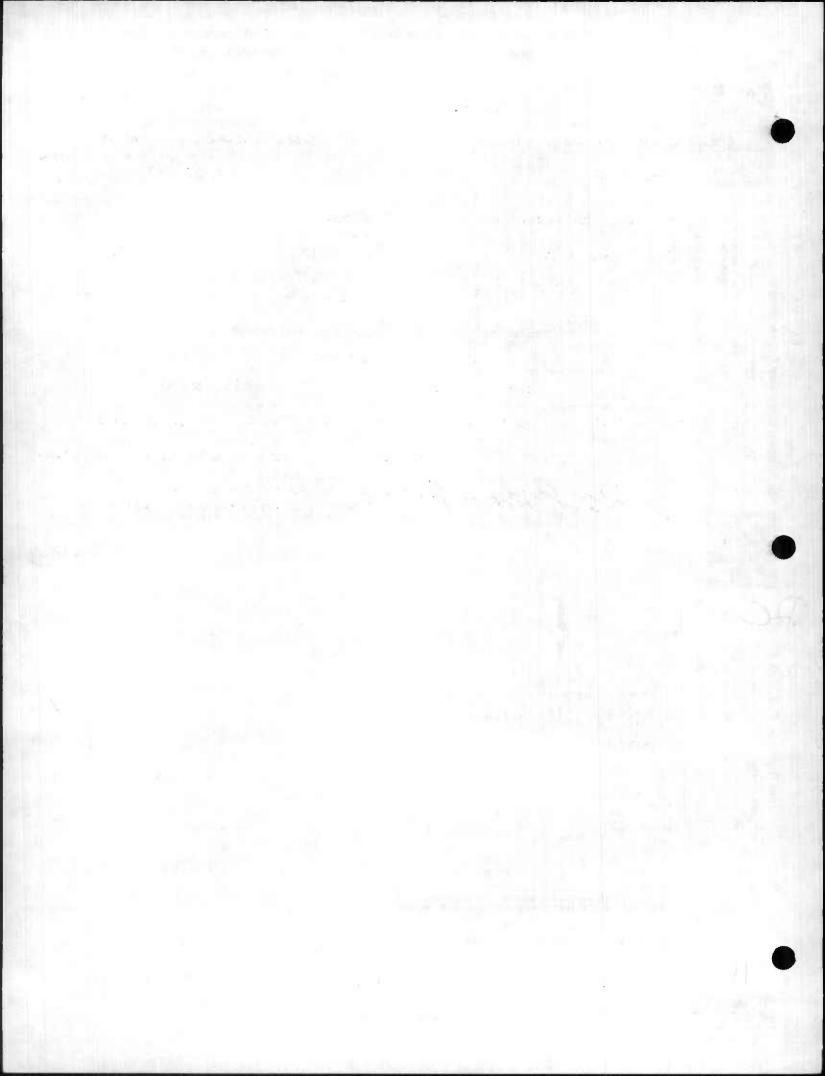
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Certification:

31. Dete filed (Month, Day, Year) MAR 1 0 1998





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 0742 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Year LOUIS GRANT February 18 1998 Н. JR. 5:50 pm 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death BALTIMORE CITY

If Undar 24 Hrs.
Hours Min.

B. Data of B. Manih, D. BON SECOUR HOSPITAL If Undar 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 1**/**(2)**X**// 2□ F Days 59 Yrs. MARYLAND 212-36-4641 Usual Residenca of Dacadant 10a Stata 10b County 10c, City, Town or Location 10d. Insida City Limits 1 Ves 2 No MARYLAND N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4000 WOODRIDGE ROAD U.S.A. 21229 12. Was Dacedant Evar in U,S. Armad Forcas? 1 ☐ Yas XIX No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. Was Dacadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Navar Marriad 2 Marriad 1 ☐ Yas 2 💢 💢 o Specify: Specify: BLACK 3 Widowed 4 Divorced Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantery/Secondery (0-12) Collega (1-4or 5+) 8th grade LABORER EASTERN PRODUCTS 17, Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) LOUIS H. GRANT, SR. LETTIE DOROTHY WILSON 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Martha Grant/Wife 4000 Woodridge Road, Baltimore, Maryland 21229 20a. Mathod of Disposition
1ADBurial 2 ☐ Cremation 3 ☐ Ramoval from Stata 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Othar (Specify) WESTERN STAR CEMETERY 2-25 BALTIMORE, MARYLAND 21. Signatura di Funaral Sarvice Licer Pas 22. Nama and Addrass of Facility WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Intarval Batween Onset and Death Immediata Causa (Final disaasa or condition resulting In daath) Sequantielly list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseasa or Injury that initiated events rasulting in deeth) Last Dua to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings aveilable prior to completion of causa of death? 24a. Was an autopsy performad? 1 ☐ Yas 2 ☐ No lisease worse on 25. Was case referred to medical axaminar 26. Placa of Daeth (Check only one) Hospital: 1 ■Inpatiant 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Items 2

should be filed within 72 hours efter and Mantel Hygiene. marked other than "natural", or ite

permit. Pages 1 end 2 should be file.
Department of Health and Mantel Hygis Important: if Itam 27 is marked any Injury or other terms.

Baltimore, Maryland 21215-0020

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P.O.

Records,

Division of Vital

the Medical Examiner must be notitied at

Director

Funeral

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Completed

Examiner Physician/Medical by Completed Be Certification: To

27. Manner of Death

1 Naturel

3 Sulcide

29a. Cartifier

2 Accident

4 Homicida

use as attending | been signed by the s should be datached I or Attending Physician: aftar death. funaral Aftar Director: / To the Hospital o within 24 hours aff To the Funeral Di completely filled in

Medical

State Registrar 29b. Signatura and titla of certifiar Erdinand S. Leavork, MD 30. Name and address of person who completed cause of death (Itam 23a) (Typa, Print) DRIVE, BALTIMORE

5 Panding Invastigation

6 Could not ba

28a. Data of Injury (Month, Day Year)

28b. Time of

Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

29c. Licansa number

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledga, daath occurred at tha time, date and place, and dua to the causa(s) and mannar as stated.

| Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to the causa(s) and mannar stated.

28d. Dascribe how Injury occurred

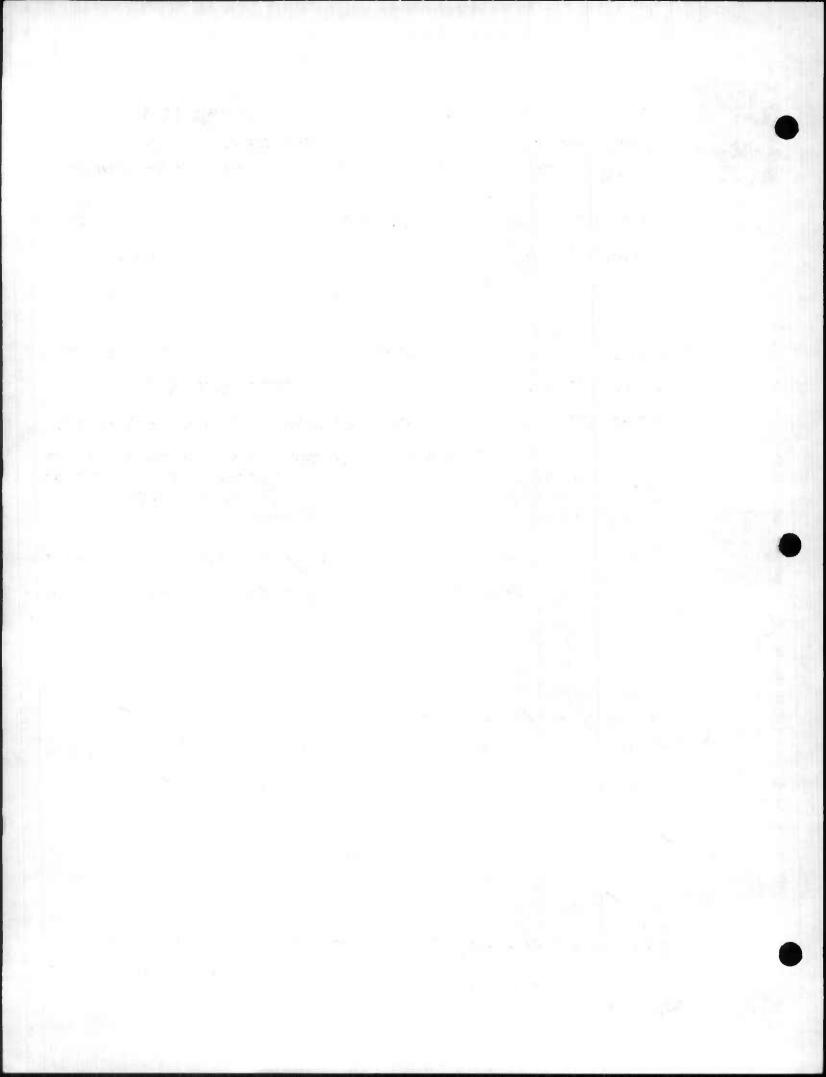
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1 Yas 2 No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

F.S. LLACOCK, M.D.



Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 98 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death **Physician** Heavener Lewis 1920 March 1998 08 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Randallstown Baltimore Northwest Hospital Center 7. Age (In yrs. lest birthdey) | If Undar 1 Yaar | If Undar 24 Hrs. 8. Date of Birth Months, Deys Hours Min. Jan. 1924 5. Soclei Security Number 9. Birthpleca (Stete or Foreign Funeral 1**10** M 2□ F North Carolina 218-12-3634 Director Usuel Residence of Decedent the Meryland 10a Stata 10h County 10c. City. Town or Location 10d. Inside City Limits Reisterstews 1 Yas 2 No Baltimore Director Md. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 7 is marked other than "natural", or items 23s or traumstic avent, the Medical Examiner rount be to 21136 U.S.A. 11715 Terry Town Drive Funeral 72 hours efter deeth 12. Wes Decedent Evar in U,S. Armed Forcas?

1 X Yas 2 No if Yes, Give Yeer or Detes: 14. Race - Amaricen Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White g 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within 7 nent of Heelth and Ments! Hygiene. nt: If item 27 is marked other than "r Etementery/Secondery (0-12) College (1-4or 5+) Western Electric Mechanical Worker 18. Mother's Neme (First, Middle, Maiden Surnama) 17. Fether's Neme (First, Middla, Last) Willie Ann Harris George T. Heavener 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code)
11715 Terry Town Dr., Reisterstown, Md. 21136 19e. Informent's Neme/Reletionship (Type, Print) Theresa G. Heavener Wife 20b. Place of Disposition (Neme of cemetery, cremetory or other place)

Lerraine Park Cemetery March 12, 1998 Woodlawn, Md. 20a. Method of Disposition permit. Peges Depertment of Important: If it any injury or o Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility

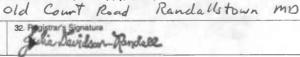
Eckhardt Funeral Chapel 23a. Part1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Physician /Medical Immediate Cause (Finel Left hemrspheric diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Diabetes nellitus vears physician end the bunal-transit certificate be executed and Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury on of Vital Records, P.O. Box 68760, Hypertention years Physician/Medicai that initieted events resulting in deeth) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. signed by the a 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 32 Probably 4 Unknown Lemispheric stroke Completed by 24b. Were eutopsy tindings eveilebte prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Respiratory failure Chronic renal failure Myocardral infanction Atrial Fibrillation 1 ☐ Yes 2 No 1 Yes 2 No 25. Was cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? Certification: 1 Neturel 5 Pending 1 Yes 2 No investigetion 2 Accident 24 hours after deet Funeral Director: S 6 Could not be 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated. 29a. Certifier (Check only one) To the I 29b. Signeture end title of certifier 29c. License number 29d. Date signad (Month, Dey, Year)

State Registrar D. Roggen 31. Dete filed (Month, Dey, Yeer) MAR 1 0 1998



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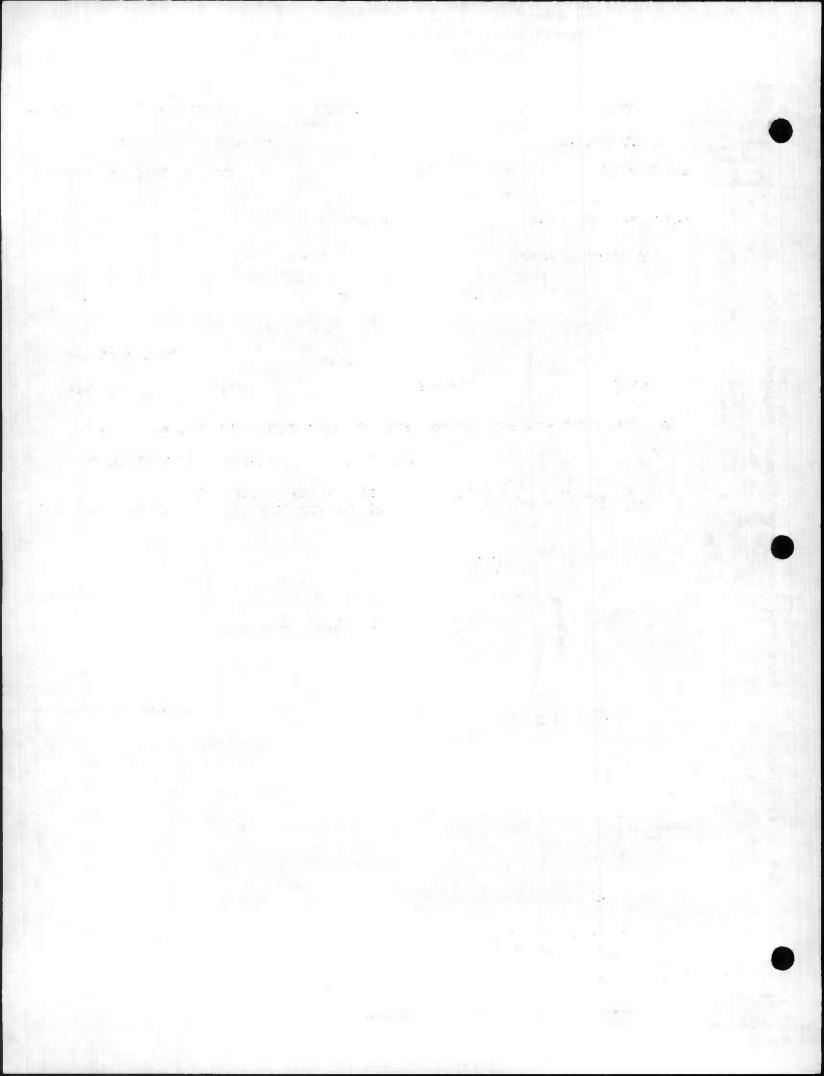
30. Name end address of person who completed cause of deeth (item 23e) (Type, Print)

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entitions described the continue of the contin

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medical		Decedent's Nam	ne (First, Middle, I	Last)						2. Dete of De		Veer	3. Time of Deeth
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xaminer		Fecility Neme (If not Institution, g	nive street and num	ber)			4	b. City, Town, or	Location of Deeth	MARCH O6 1998 5:50 MARCH O6 1998 5:50 Ac. Country of Deeth N/A Pole of Birth N/A Pole of Birth Month, Dey, Year) DCT. 7, 1915 9. Birthplece (Stete of Country) PENNSYLVA 10d. Inside Ci 1 Yes 10g. Citizen of What Country? USA Yes or Nongle of Business/Industry WHITE 16b. Kind of Business/Industry WOMENS CLOTHING St. Middle, Maiden Surmeme) IIE KESSLER Ute Number, City or Town, Stete, Zip Code) JETIMORE, MD 21209 St. JINC. De PIKESVILLE, MD 2120 Approximatintervel Bet Onset end to Surge of Surg		
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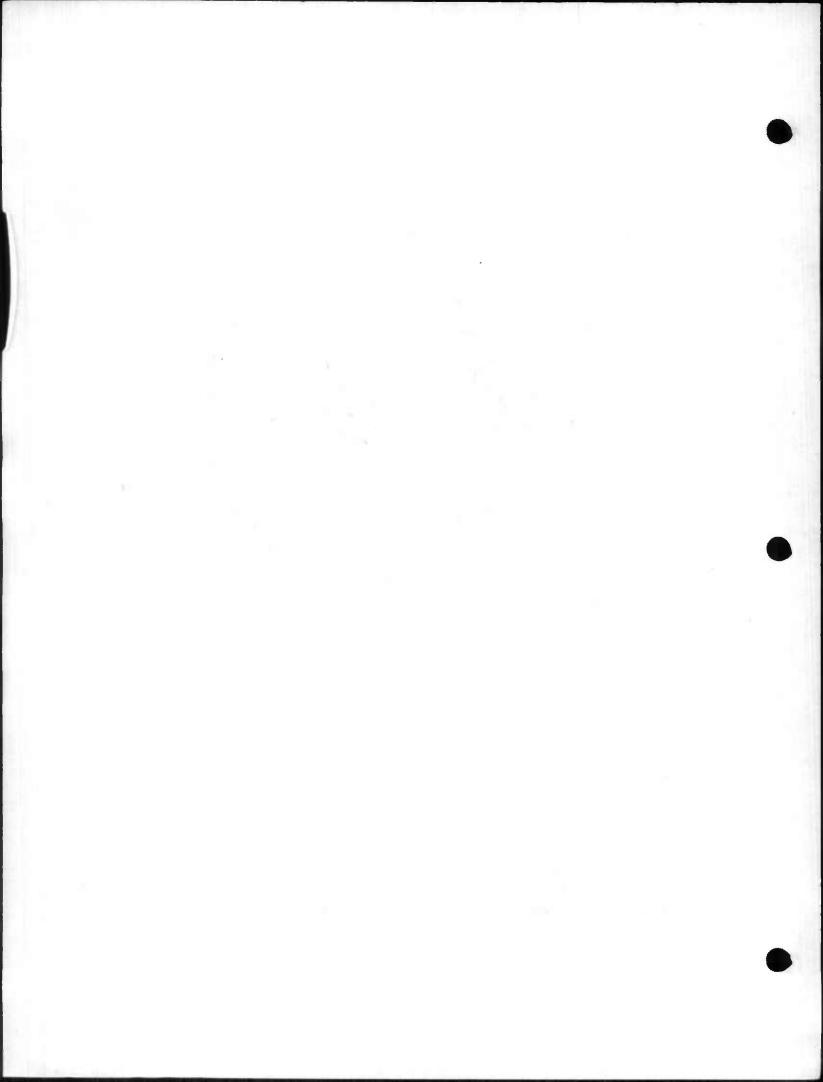


DIVISION OF VITAL RECORDS, P.O. BOX 6876

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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be re	ECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5
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YSICIAN: the law requires that the objain certificate be executed within 24 mouts after objain. Tayle o may be retained by the hospital of attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	r death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	d or New 23 shows any injury or other traumatic event the medical examiner must be notified at once.
law requires tr	as been signed	Jept. of Health	23 shows at
CIAN: Ine	pertificate h	the State I	or Ham
JING PHYS	this	er death with	marked
H ALLEND	RECTOF	ours after d	arn 28 le
PIIAL O	JNERAL DI	n 72 ho	FANT: If item 28
THE HOS	TO THE FUN	be filed within 72 hours after	MEDORTAN

	1 - STATE OF MARYL REGISTRAR	AND / DEPART			MENTAL HYGH			
	1. DECEDENT'S NAME (First, Middle, Last)		J/ (1 L O 1	DEATH	2. DATE OF DEATH			3. TIME OF DEATH
4	Tina Hines				MARCH 9	, 199	YEAR 8	6:00 AM
d.		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTI	IPLACE (State or Foreign
	579-44-9147 1 M 2 RF	65 YRS.	IONTHS DAYS	HOURS MIN.	OCT 29.	1932	Nor	th Carolina
	9a. FACILITY NAME (If not institution, give street and number)		Db. CITY, TOWN	OR LOCATION OF D			NTY OF D	
FUNERAL DIRECTOR	1931 Foxhound Court		Severn			Ar	ne .	Arundel
ايُ	District of 10b. COUNTY	10c. CITY,	TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS?
5	Columbia N/A	Wasi	hington					1 TYES 2 NO
	10e. STREET AND NUMBER		10	I. ZIP CODE		10g. CITI	ZEN OF	WHAT COUNTRY?
į	3322 14th St. N.W. Apt. 517			20010		J	JSA	
5	11. MARITAL STATUS 12. WAS DECEDENT EVER II 1 Name Married 12 Married 13 PARTIES 14 PARTIES 15 PARTIES 16 PARTIES 17 PARTIES 18 PARTIES 18 PARTIES 19 PARTIES 10 PARTIES 10 PARTIES 11 PARTIES 12 PARTIES 13 PARTIES 14 PARTIES 15 PARTIES 16 PARTIES 17 PARTIES 18 PARTIES 19 PARTIES 10 PARTIES 10 PARTIES 10 PARTIES 11 PARTIES 12 PARTIES 13 PARTIES 14 PARTIES 15 PARTIES 16 PARTIES 16 PARTIES 17 PARTIES 17 PARTIES 18 PARTIES 18 PARTIES 19 PARTIES 10 P				NIC ORIGIN? (Specify an, Puerto Rican, atc.)	Yes or No-	14. RACI	E — American Indian, k, White, etc.
	1 Never Married 2 Married IF YES, GIVE WAR OR D. 31 Wildowed 4 Divorced			2 NO Speci				Black
	15. DECEDENT'S EDUCATION	40. 05050511710 11	1		I was some an			DIACK
Committee of the commit	(Specify only highest grade completed)	16a. DECEDENT'S U: (Give kind of wo life. Do NOT use	rk done during me	ost of working	16b. KIND OF	BUSINESS/INC	USTRY	
	Elementary/Secondary (0-12) College (1-4 or 5+)		•		77			
	17. FATHER'S NAME (First, Middle, Last)	Homemake	r	Les MOTHERIS M	ME (First, Middle, Mail	estic		
	Floyd Norwood 19a. INFORMANT'S NAME (Type/Print)	T 405 MAIL INC. 4	DODESC (Communication)		ora Morro		0	
	Cathy A. Ponton/daughter							
					ltimore,	LOCATION -		
		p.PLACEANDDATE OF control of control of the control	er piece)		1			
	21. SIGNATURE OF PUNERAL SERVICE UCENSEE	erro creme	22. NAME A	ND ADDRESS OF F	/10/98 B	artimo	re,	MD
	Lamn I'mc Hom	old.	Crema	tion Soc	iety of M	arylan	d, 1	inc.
	Dawn F. McDonald	our	299 F	rederick	Rd. Balt	imore,	MD	21228
	23. PART I. Enter the disesses, or complications that cause shock, or heart feilure. List only one cause on a	d the death. Do no	t enter the me	ode of dylng, suc	ch aa cardisc or re	apiratory an	reat,	Approximeta interval Between
	***************************************			0.				Onset and Death
	disease or condition a. ACU To	E REN	ML	MIL	RE			
	DUE TO (OR AS /	CONSEQUENCE OF)						
	- METTSTAT	IC BLA	DER	CANZI	ER.			
	If any, leading to immediate	A CONSEQUENCE OF):						
	cause, Enter UNDERLYING CAUSE (Disease or Injury							
	thet initieted events DUE TO (OR AS A resulting in death) LAST	A CONSEQUENCE OF):						
	d.							
	PART II. Other aignificent conditions contributing to death b	out not resulting in	the underlying	g cause given in	Part i. 24s. WAS	AN AUTOPSY	248	. WERE AUTOPSY FINDINGS
	CANZER OF CERVIX				PER	FORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	CANSER OF ESOPHA				1 YES	2 X NO		DF DEATH?
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF		NO E	UNCERTA	N D			1 YES 2 XNO
	25. WAS CASE REFERRED TO MEDICAL	28. PLACE OF DEATH		JUNCERIA	17 🗀			
	EXAMINER? HOSPITAL:		OTHER:	V	(April 10)			
	1 YES 27 NO 1 Inpatient 2 ER/Out 27. MANNER OF DEATH 28e. DATE OF INJURY	28b. TIME	Nursing Hor	JURY AT	6 Other (Specify)	W IN ILIEN OC	CURED	
	1 Natural 5 Pending (Month, Day, Year)	INJU	RY W	ORK?	200. DESCRIBE NO	W INJUNI OC	CONED	
	2 Accident Investigation 3 Suicide Could not be 288. PLACE OF INJURY	/ At home form st			28t, LOCATION (Str	at and Mumba	or Own!	Doub Number
	3 Suicide 6 Could not be determined 288. PLACE OF INJURY building, etc. (Spe	city)	reet, ractory, orn		City or Town, Si		OF PIDFIE	Plodie Nomoer,
	29s. CERTIFIER							
	(Check only							
	2 MEDICAL EXAMINER: On the besis of exemination	on and/or investigation.	, in my opinion,	death occured at the	time, data and place	, and due to th	ne ceuse(a) end manner as stated.
	29b. SIGNATURE AND TITLE OF CENTURES			29c. LICENSE NU	MBER	29d. DAT	E SIGNE	(Month, Day, Year)
	reconsole MD			11/6	364	P 3	3/0	198
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type, F	Print)		(D. D.			
	Peter Graze mo, 900	DESTRAK	C (101)	JIHK 3	100, Ann	pulis	n	10 MG 101
	31. DATE FILED (Month, Day, Year) // 32, REGISTRAR'S SIGN	VATURE			· •	-		
	MAR 1 0 1998 Julia Davidson	Marines						

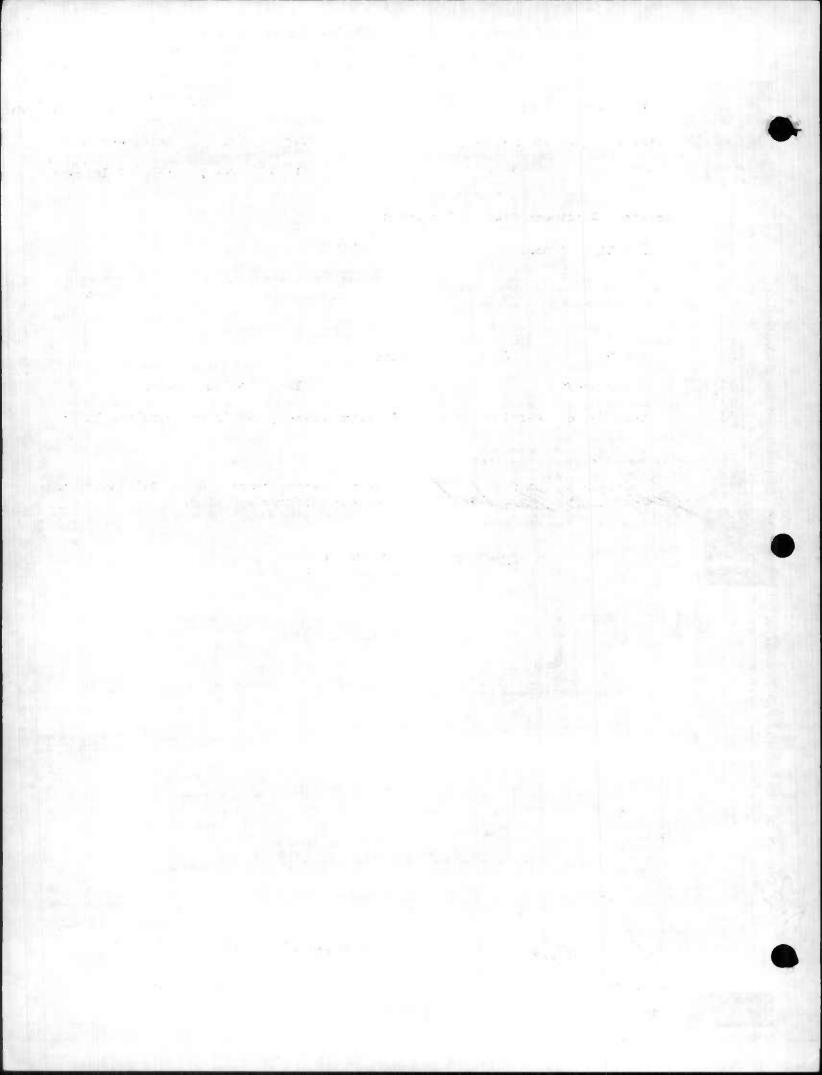


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 02 9:25 pm **Physician** Baby Girl Harris /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner Baltimore Medical Baltimore City Mercy Center 9. Birthplace (State of Foreign Country Maryland If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1□M 20 F Days Hours Months 30^{Min} none Yrs. Feb. 27, 1998 Baltimore Director Usuel Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location t0d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar name be notified at Baltimore City 1 X Yes 2 ☐ No Baltimore Maryland Directo 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 21216 U.S.A. 2314 Riggs Avenue permit. Pages 1 end 2 should be filed within 72 hours efter death v Doctriment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a my injury or other traumatic event, the Marie Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 PNever Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) none 0 none none 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Harvey Kenyon Tonya Monique Harris 2 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tonya Monique Harris 2314 Riggs Avenue, Baltimore, Maryland 21216 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □Other (Specify) in state 21. Signature of Funeral Service Licensee Joseph B Van 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street 13. Baltimore, Maryland 21201 Datititione, Maryiand 21201

23a Pant Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate tntervel Between Onset and Death Physician Immediete Ceuse (Final diseese or condition resulting in death) /Medical Drematu Examiner Due to (or as a consequence of) Examiner attending physician and for use as the bunal-trensit thet the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) 88 signed by the a 23b. Did tobacco use contribute to the cause of deeth? Part It. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, b 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? page 2 s certificate has 1 Yes 2 No 1 Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Dele of Injury (Month, Day Year) funeral 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After 5 Pending Investigation 1X Natural s efter death. 1 Yes 2 No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours effer To the Funeral Direct 4 Homicide 29e. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end placa, and due to the cause(s) and manner es stated. edicai complately 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mercy Medical Center, Battimore, mi Levin, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) 0 1998 Registrar

DHMH 16 Rev 6/95

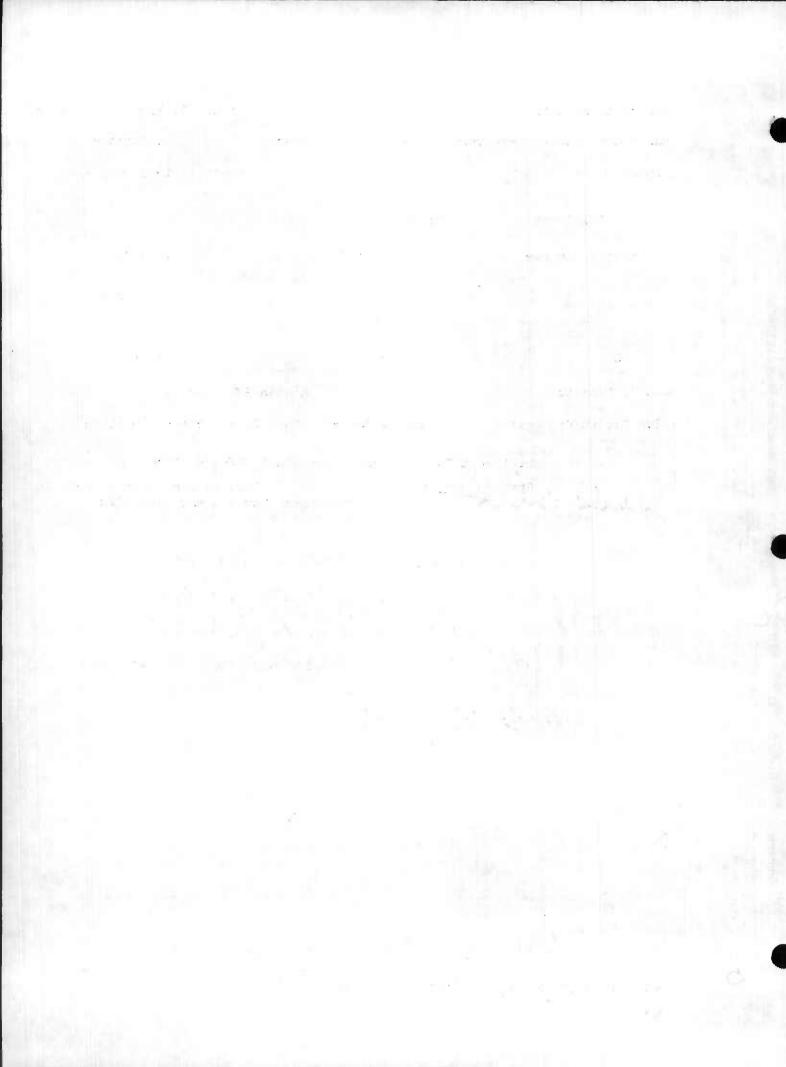


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State of Maryland / Department of Health and Mental Hygiene) 8

Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month **Physician** Marguerite E. Heil 7, 1998 March 4:15 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Manor Care Health Services- Towson Towson Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** 1□M 2\ F Hours Yrs. Director 212-32-9404 April 6, 1902 Maryland Usual Residence of Decedent the Maryland r 28a-f show 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code and Mental Hygiene. Is marked other than "natural", or items 23a or sumstic event, the Medical Examinal must be a with 500 Virginia Avenue 21286 United States Funeral filed within 72 hours efter death 14. Race · American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2000 Specify: Specify: White by 3 Widowed 4 Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Sales Person Bakery 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental th Important: If Item 27 is marked oth any linjury or other traumatic even Roce. John T. Bennett Minnie NMN Webster 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Melva Crogan/Daughter 205 E. Joppa Rd Apt. 2209 Towson, MD 21286 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specify)entombment Dulaney Valley Mausoleum 03/09/98 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line. Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Asallation Physician/Medical 96 that initiated events resulting In deeth) Last les als Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Records, P.O. # 2 signed by 1 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed law. Pass 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical exeminer? 88 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 20 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) Certification: Attending 5 Pending 1 Natural 1 Yes 2 No investigation 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Sig b hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end manner as stated.

20 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) ž and manner stated. To the Wilhin 2 To the 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number pleted cause of deeth (Item 23e) (Type, Print) 30. Name end address of person HAMM 31. Date filed (Month, Dey, Year) Registrar



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State of Maryland / Department of Health and Mental Hygiene 8

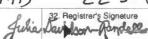
					C	ertificat	e of	Death	1		Reg. No.	0 01	- Y C
Dhunin		1. Decedent's Name (First, Mic	Idle, Last)								eath	Vons	3. Time of Death
Physic /Medi		FRANK	HOLTZNE	R						MARC	H 5	200	12:40 pm.
Exami		4a. Facility Name (If not institut	ion, giva street and nu	n <i>ber)</i>				4b. City, To	wn, or Lo	ocation of Deat	th 4c. C	ounty of Death	
		117 NORTH HAM	MONDS FERR	Y ROAD				LINT	HICU	M	Z	ANNE ARU	INDEL
Funeral Director		5. Social Security Number 219-10-8478	6. Sex 1 ☐ MM 2 ☐ F	7. Age (In yrs 76		Months			24 Hrs. Min.	8. Data of Bi (Month, Do 06-01-	rth ey, <i>Year</i>) 1921	9. Birthp	
ъ		Usual Residence of Decedent							2. Date of Death Month M				
ahow a how	_	10a. State 10b. Coun	•									1	Od. Insida City Limits
Ne M	cto		Arundel	Lli	nthicu	ım							1½JYes 2∐No
th with the 23a or 2	Funeral Director	10e. Street and Number 117 North Ham	monds Ferr	y Road						Reg. No. 2. Date of Death Month PARCH Day Year 1998 2: 26 Country of Death CUM ANNE ARUNDEL Hits. 8. Date of Birth, Death (Month, Death Of Death). 9. Birthplace (Stere or F. Country). MD 10d. Inside City to 1909. 10d. Inside	ntry?		
deed	ner	11. Marital Status	12. Was Dece	edent Ever In	Centificate of Death 2 Date of Death 2 Date of Death 2 1,9 9 3 3. Time 2 2 Date of Death 2 1,9 9 3 2 3 3. Time 2 2 2 2 2 2 2 2 3 3								
within 72 hours efter deeth with the Meryland ena. than "natural", or items 23s or 28s-f show he Medical Exeminer nust be notified at	by	1 Naver Married 2 Ma 3 Widowed 4 Divorce	arried 1 Tes	Certificate of Death Certificate of Death									
2 ho	Completed		ent's Education		16a. De	cedent's Usua	al Occu	pation			16b. Kind	d of Businass/Inc	dustry
The Car	ple	Elementary/Secondary (0-12		-4or 5+)	life			auring mos ad)	it of work	ing	- 7	1	
gien gien	-OC	5				Plumbe	r				Plu	mbing C	
be filed with ntal Hygiena. od other then event, the M	Be (17. Fathar's Name (First, Middle	a, Last)				Ab. City, Town, or Location of Death Anne of	umeme)					
Vents Vents rked rice	To	Joseph Holtzne	r					Mar	gare	t Hicke	У		
s 1 and 2 should be filed within f Health and Mental Hygiena. them 27 Is marked other than "other traumatic event, the Me		19a. Informant's Name/Relation Peter R. Giuli		riend									
Health tem 27 l		20a. Method of Disposition		20b.	Plece of Dis	position (Ner	ne of	10		Date	20c. Loca	ation - City or To	own, State
permit. Peges 1 end Department of Health important: If Item 27 any Injury or other tr once.		1 Surial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other	(Specify)				ther ple	ece)	3,	/9/98	Balti	more, M	đ
Departiment important		21. Signature of Funeral Service	e Licansee	'5		terlin	g A	shton	Fune				200
		23a. Part1. Enter the disease,	or complications that c	aused the dea	ath. Do not o	36 Eam	lond le of dy	ing, such as	cardiac	Catonsv or respiratory a	TILLE,	Ma. 21	Approximate
Physician		Shock, of fleatt failure. Li	st only one cause on a	ach line.								i	Onsat and Death
/Medicai		Immediate Cause (Final		ARDIA	2/	ani	CHUTH	m'	1		1	5 Municipal	
Examiner		disease or condition resulting in death)	a					-11011	11/79				o may es
	Jer			D04 (0 (Sunc.	^			1	5 YEAR!
ansit	Examiner	Cognoptially list conditions	b	Due to /			316	2003/				i	3 / 3
com and buriel-transi	EX.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury					50.05	77 01	m 0 10	. IAC INI A A	0.00	aic-	10 WEARS
a pa	cal	that initiated events	С				jour	ic cm	RVIO	VITSOUTH	- VISC	"JE	10 40/1/0)
anding physus use as the	/Medical	resulting in daeth) Last	d	D08 t0 (or as a cons	equence or).							
for	Physician	Part II. Other significant condi-	tions contributing to de	ath but not re	sulting in the	underlying c	ause g	iven in Part	1.	23b. Did	tobacco us	se contribute to	the cause of death?
igned by the	by Phy	REFLU	(ESOPHA	61175						10	Yes 2€	No 3□ Prot	bably 4 Unknown
s been s 2 should	Completed t									24a. Wes	an eutopsy ormed?	avi coi	aitable prior to mpletion of cause
De la la	0									10	Yes 2 🕅	No 1E	Yes 2□ No
rnysician: In this certificata rel director, peg	Be	25. Was case referred to medic	al					26. Place	of Deetl	h (Check only	one)		
00	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2	ER/Outpat	ient 3□ DC	Ot Ot	hor				Other (Specifi	v)
Affer fune	tion: T	27. Mannar of Death 1 Natural 5 Pend	28a. Date	-	28b. Time	of 2	8c. Inju	iry at ork?					Approximate Interval Between Onset and Death 5 MINUTES 5 YEARS 10 YEARS 10 YEARS 10 YEARS 10 YEARS 11 Yes 2 No
To the Hospital or Attending within 24 hours aftar death. To the Funeral Director: Afte completely filled in by the fune	Certification:	2 Suiside 6 Could not be											
To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical C	29a. Certifier (Check only one) Certify	I Examiner: On the ba	sis of examina	owledge, de ation and/or	ath occurred Investigation,	at the t	ime, date an opinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) as date end p	nd manner as st lace, and due to	tated. the cause(s)
o the	M	29b. Signature end title of certif				290	. Licen	se number			29d. Date	signed (Month	Day, Year)
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45		30. Name end eddress of perso	n who completed caus	e of death (Ite	m 23a) (Typ	e, Print)	110	ACE	20	2.1011 V	2d 61	en Bur	is Ald sin
Sta		31. Date filed (Month, Day, Yea MAR 1 0199)					0 101	V// C	OIU	11000	W -11		14 51060
Registr	ar	וווייות ד עולוווי		-widdeli-	Martingo								

Items: 23a Part Ia-d Per MD Film G-757 3-10-98RC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** LINDA HAYES 3: 10 AM 02 /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL SYSTEM RALIMORE If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 7. Age (In yrs. lest birthday) 9. Birthpiece (State or Foreign **Funeral** 388 1□ M 25€ Deys Hours 32 PENNSYLVANIA 5 Director Usuel Residence of Decedent the Maryland 10e Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No Director MARYLAND HARFORD **ABERDEEN** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours aftar death with in ant of Haalth and Mental Hygiena. Evaminar must be r 370 STRATFORD AVENUE 21018 U.SA. Funeral 12. Wes Decedent Ever In U,S. Armed Forces?,
1 Yes 220 No If Yes, Give Year or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck. White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 natural', or 1□ Yes 2XXNo þ Specify: BLACK 3 Widowed X Divorced the Medical E Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry Eiamentary/Sacondary (0-12) Coilega (1-4or 5+) DEPT. STORE 12th grade SALESPERSON 7 is marked other traumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middle, Meiden Sumeme) PAUL WILSON SUSIE O. HITE 19a. Informent's Name/Raletionship (Type, Print) 19b. Meiling Addrass (Straet and Number or Rurel Route Number, City or Town, State, Zip Code) tam 27 is other tra 370 Stratford Avenue, Aberdeen, Maryland 21018 Norma D. Newell 20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, Stete Date XX Burial 2 Cremetion 3 Removel from State = 0 permit. Page Department of Important: If any injury or once. MT. Peace Cemetery 3-6-98 PHILADELPHIA, PA 4 ☐ Donetion 5 ☐ Other (Spacify) 22. Name end Address of Fecility WILLIAM C. BROWN COMMUNITY F/H 21. Signature of Funeral Service License 1206 W. NORTH AVENUE Part Leniar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervei Between Onset end Deeth **Physician** /Medicai Immediate Ceuse (Finei diseesa or condition rasulting in deeth) · CEREBRAL HERNIATION SYNDROME Unknown Examine Due to (or es e consequance of): Examiner SUBDURAL HEMATOMA Unknown Sequentially list conditions, if eny, leeding to immedieta cause. Entar Underlying Cause (Disease or injury that Initieted events resulting in death) Lest Due to (or es e consaquence ot): Division of Vital Records, P.O. Box 68769 COAGULOPATHY Unknown Physician/Medical Due to (or es e consequenca of) Unknown MULTIPLE MYELOMA igned by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings evailable prior to completion of cause ot death? 24e. Wes en eutopsy performed? Completed page 2 s certificata 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after daath. Funeral Director: After this certifica 25. Was casa reterred to madical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yas 2 No Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Daath 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Piece of injury - At home, ferm, street, tactory, office building, etc. (Specify) 4 ☐ Homicide 24 hours 29a. Cartifier 1 Cartifying Physician: To tha best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end the time of the ceuse(s) and the ceuse(s) and the ceuse(s) are the ceuse(s) and the ceuse(s) and the ceuse(s) are the ceuse(s) and the ceuse(s) are the ceuse(s) and the ceuse(s) are the ceuse(s) and the ceuse(s) are t Medical To the To the To the 29c. License number AU4(764355936) 09361 29b. Signature end title of certitler - R.SWAMI MD 30. Name end address of person who completed causa ot daath (Itam 23e) (Type, Print) 22 S. GREENE ST DEPT. OF NEUKOSURLERRY R. SWAMI, MD

State Registrar 31. Deta tilad (Month, Dey, Year)

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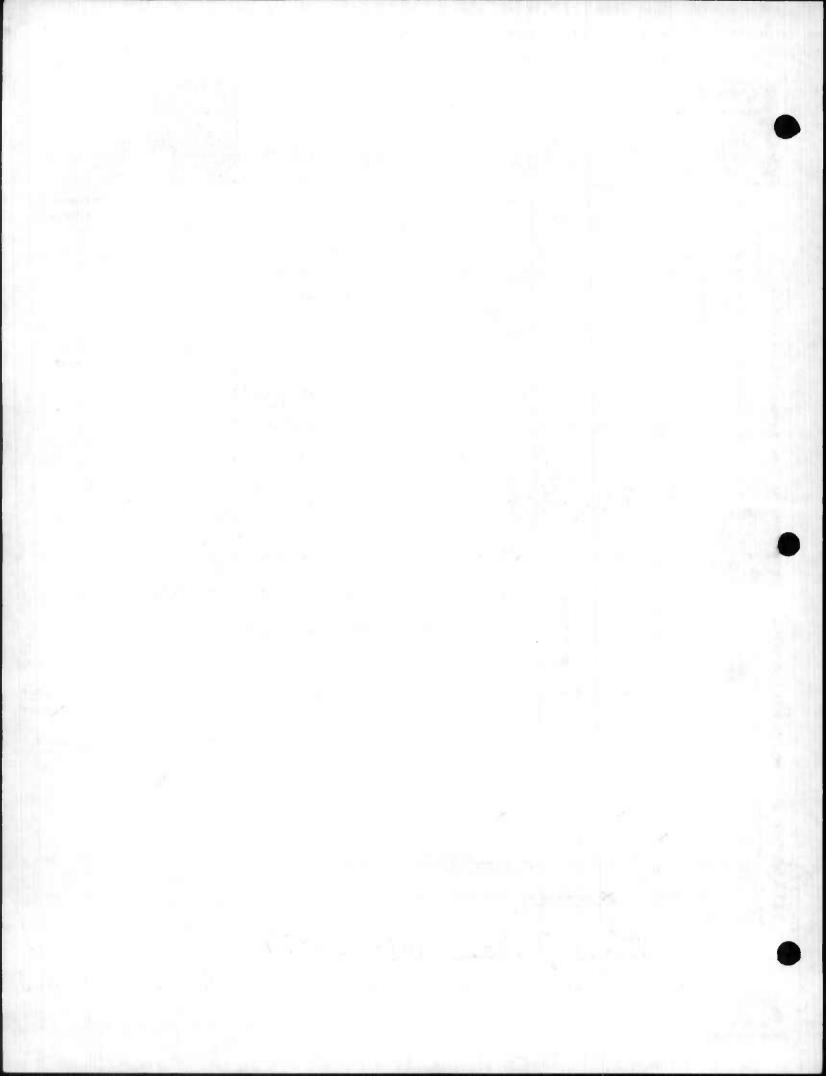
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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death 2. Data of Deeth Month MAR HOWAR 4b. City. Town, or Location of Death 4c. County of Death Annapolis 6 Sax 7. Aga (In yrs. last birthday) Months

1. Decedent's Nama (First, Middla, Last) 3. Tima of Death 49 **Physician** MARNITA /Medical 4a. Fecility Nema (If not institution, give street and number) Examiner Anne Arundel Medical Center Anne Arundel County if Under 1 Year | If Undar 24 Hrs. | Months | Days | Hours | Min. | 8. Dete of Birth (Month, Day, July 13, 5. Social Security Number Birthplaca (Stata or Foreign Country) **Funeral** 1□M 2X1F Days Yrs 48 Director 216-56-8695 1949 Maryland Usual Rasidance of Dacedent Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland nent of Heatth and Mental Hygiene. Int. If Itam 27 is marked other than "natural; or Items 23s or 28s-f ahow rry or other traumetic event, the Medical Examiner must be notified at 10a Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yas 25 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zin Coda 10g. Citizan of What Country? 21 Mooring Point Court 21403 U.S.A. Funeral 12. Was Decedant Ever in U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Maxican, Puarto Rican, atc.) 11. Maritel Status 14. Race - American Indian, Black, Whita, atc. 1 XNever Marriad 2 ☐ Merried l ∐Yas 2X No lf Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No by Specify: 3 Widowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Years Business Administrator Telephone Company 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Be John Thomas 2 Howard June Charlotte Schuster 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Barbara Louise Hester/Sister 11911 Bluestone Road, Kingsville, Maryland 21087 20b. Place of Disposition (Nama of cematary, cramatory or other place) 3/6/98 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Crametion 3 ☐ Ramoval from State permit. Pege Depertment important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Baltimore/Washington Crematory Laurel, Maryland John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 that caused tha daath. Do not antar the mode of dying, such as cardiac or respiretory errest, Approximete Interval Batw **Physician** Immediate Causa (Final disaasa or condition rasulting In death) /Medical METASTATIC COLON CANCER MONTHS Examiner Dua to (or as a consequence of): Examiner The lew requires that the deeth certificete be executed physician end the buriel-transit Sequentially list conditions, if eny, laeding to immedieta cause. Entar Undarfying Cause (Disaasa or Injury thet Initiated evants resulting in daath) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) 950 Po signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Wara autopsy findings available prior to complation of cause of daath? Completed 24a. Was an autopsy performed? peeu hes page 2 certificate 1 Yas 1 ☐ Yas 2 ☐ No Attanding Physician: director, Be 25. Wes casa rafarred to medical exeminar? 26. Placa of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 2 1 Inpetiant 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred Certification: 28b. Tima of 1 Naturel fler death. Director: Af 2 Accident

5 Pending Invastigation

6 Could not be datermined

3 Suicide

29a. Cartifier

4 Homicida

28a. Piace of injury - At homa, farm, streat, factory, office building, atc. (Specify)

1 ☐ Yas 2 ☐ No 28f. Location (Streat and Number or Rural Routa Number, City or Town, State)

Certifying Phyeician: To tha best of my knowledge, daath occurred at the tima, data and place, and due to the causa(s) and mannar as stated.

Medical Examiner: On the basis of axaminetion end/or invastigetion, in my opinion, deeth occurred at the tima, data and place, and due to the cause(s) and mannar statad.

29b. Signetura and the of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Nama and eddrass of person who complated causa of death (Item 23e) (Type, Print)

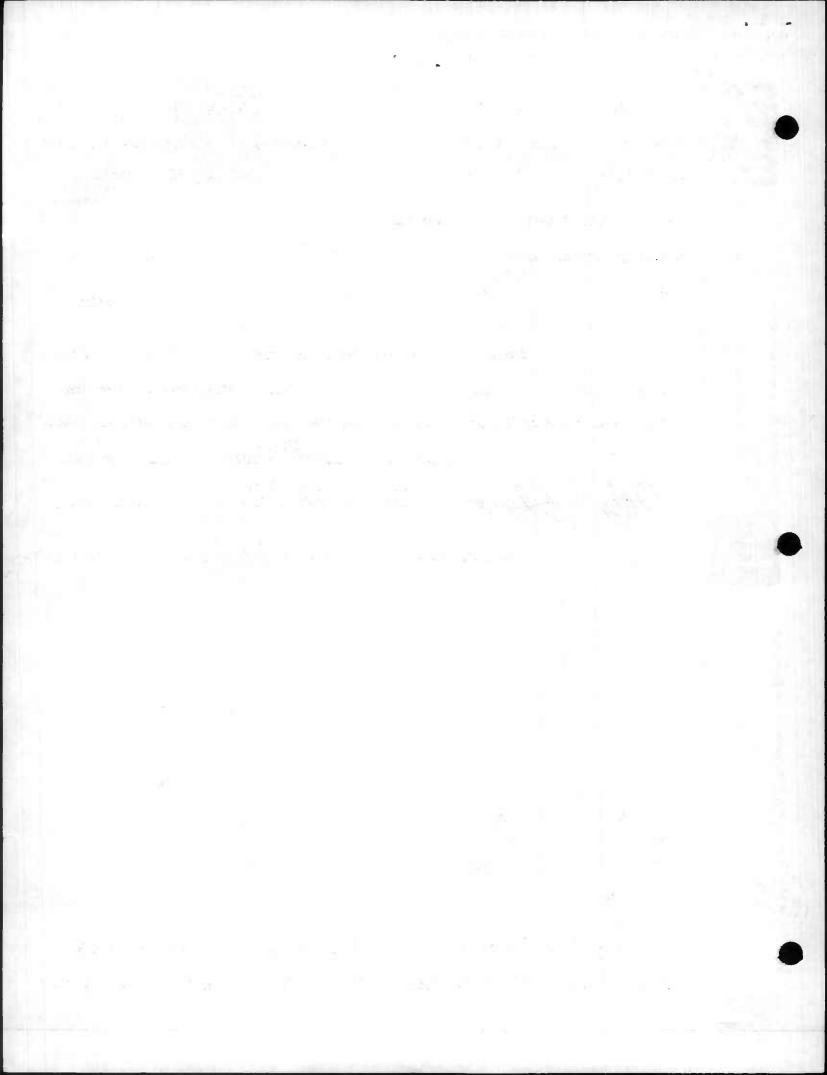
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31. Dete filed (Month, Dey, Yeer) SUITE 300 ANNAP MO 2140/ 31. Dete filed (Month, Dey, Year) MAR 1 0 1998 32 Registrary Signature

State Registrar

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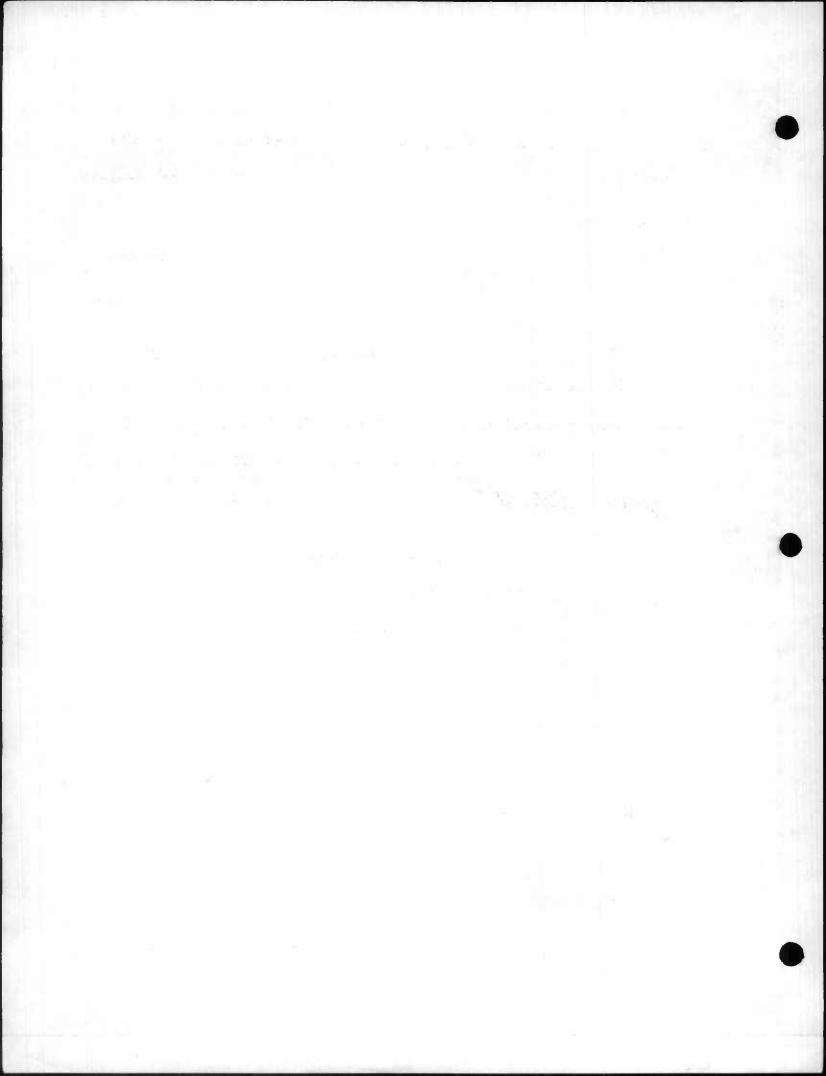


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Yeer OYNER CLLEN 11:10 AM MARCH 1998 08 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Double Examiner BALTIMORE SAMARITAN HOSPITAL (7000 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) July 2, 1934 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months Days Hours Director 213-32-5173 Yrs. Maryland Usual Residence of Decedent tha Meryland 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 6721 Glenkirk Rd. 21239 Herms 23a United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 72 hours eftar 1 Never Married 2 Married ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specity: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within; Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any Injury or other traumatic event, the Med obtes. Elementery/Secondery (0-12) College (1-4or 5+) 12 realtor real estate 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Raymond Franklin Ehrhart Elizabeth Bernadette Coughlan 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Charles Gregory Joyner/husband 6721 Glenkirk Rd. Baltimore, MD 21239 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Gardens 3/13/98 Timonium, Maryland 22. Name and Address of Fecility Mitchell-Wiedefeld Home, Inc. 21. Signeture of Funeral Service Licensee 6500 York Rd. Baltimore, MD Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one ceuse on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediete Cause (Final INTRACEREBRAL disease or condition resulting in deeth) Examiner Physician/Medical Examiner METASTASIS ettanding physician and for usa as tha bunal-transit The law requires that the death certificets be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. BREAST CANCER Due to (or es a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en autopsy performed? peen page 2 s 1 Yes 2 □ No 1 ☐ Yes 2 No Aftar this cartificate Division of Vital Attanding Physician: director. Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) exeminer? Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending Investigation 1 Natural n 24 hours after daath; e Funantil Director: Aft plotely filled imby the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 18 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end manner stated. Medical 29a. Certifier (Check only one) To the L within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P10581 Lyman MARCH Koteish ND AYMAN KOTEISH, MD 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) RAVEN BLVD BALTIMORE LOCH 42. Registrer's Signature 31. Date filed (Month, Day, Year) State MAR 1 0 1998 Registrar

DHMH 16 Rev 6/95



3-10-98RC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Item: 8 Per FH Film G-757 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** JAMES 9155 PM JONES 1998 /Medical MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORIS UNIVERSITY OF MARYLAND MEDICAL SYSTEM BALTIMORE If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**⊠**M 2□ F 218-64-224 40 Yrs Director JUNE 20, 1998 MARYLAND Usual Residence of Decedan 957 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show traumatic event, the Medical Examiner must be notified at NIA MARYLAND BALTIMORE 1 ¥ Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 472 items 23a 21201 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No P Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Dacedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiena. Elamentary/Sacondary (0-12) Collage (1-4or 5+) permit. Pages 1 end 2 should be filed w
Depertment of Health and Mental Hygien
Important: If Item 27 is marked other th
any Injury or other treumation. 12TH GRADE ABORER Gordon Garrett Drum Co 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be SHIRLEY SMITH JAMES D. 50NES 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY BANKS (MOTHER) 472 timore Maryknd 21201
20c. Location City or Town, State lanse. OW 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 3-10-98 Randallstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 21. Signature of Funeral Service Licensee 22. Name end Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, RA 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximata Interval Between Approximata Interval Between Onsat end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) NETASTATIC RENAL COLL CARCINOMA 6 months Examiner Due to (or as a consequence of): Examiner The law requiras that the death certificate be executed Sequentially list conditions, if any, laading to Immediata cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting In death) Last attending physician and for use as the burial-tran Dua to (or as a consequence of): Box 68760, Physician/Medical Dua to (or as a consequance of) P.O. I Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown DIAbutes Millitus Records, P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen page 2 s this cartificete 2 X No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residance 8 Other (Specify) Certification: To 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Aftar 5 Pending investigation 1 Natural To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Al completely filled in by the fu 1 ☐ Yas 2 ☐ No 2 Accident 3 Sulcide 6 Could not be Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 12 Certifying Phyalcian: To the bast of my knowledga, daath occurred at the time, date and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the bast of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and mannar stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of orthice 29d. Date signed (Month, Day, Year) 29c. License number 10218 3/5/98 m 30. Name and addrass of parson who completed cause of death (Item 23a) (Type, Print) JASON BIRNDAUM 22 South GREEN STRUKT 31. Date filed (Month, Day, Year) 32. FleeIstrar's Signature State MAR 1 0 1998

Registrar

State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death

If Undar 1 Yaar If Undar 24 Hrs.

Months Deys Hours Min.

Deys

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(s) end mennar es steted.
2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner steted.

29c. Licensa number

Physician /Medical **Examiner**

4e. Facility Nama (If not institution, giva street end number) SECOURS

10b. County

N/A

DANIEL

5. Sociel Security Number

250-14-6979

10a State

MARYLAND

Usuel Rasidence of Decedent

JENKINS HOSPITAL

81 Yrs.

10c. City, Town or Location

BALTIMORE CITY

7. Aga (In yrs. last birthday)

1**以** № 2□ F

Month MARCH

Funeral

Director the Maryland

ns 23a or 28a-f show itams 23a "naturel", or

Pages 1 end 2 should be filed within nent of Health end Mental Hygiene. int: if item 27 is marked other then permit. Pages 1 end 2: Depertment of Health er Important: if item 27 is any injury or other trau

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

P.O. Box 68760, the Records, Division of Vital this After t

To the Hospital or Attending PI within 24 hours efter death.
To the Funeral Director: After the completely filled in by the funere

Director 10a. Street and Number 10f. Zip Code 1009 ASHBURTON STREET 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forcas?
XIX Yes 2 □ No
If Yes, Give 45/46
Year or Dates: Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 1 ☐ Yes XX No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondery (0-12) College (1-4or 5+) JANITORIAL FLOOR SPECIALIST 6th grade 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) DANIEL JENKINS, SR. MARIE D. JENKINS 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Pauline Jenkins/Wife 1009 Ashburton Street, Baltimore, Maryland 21217 20b. Placa of Disposition (Nema of cemetery, cremetory or other pleca) 20a. Method of Disposition 1 X Suriel 2 ☐ Cremation 3 ☐ Removel from Stete ARBUTUS MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signature of Funerel Service Licarus 22. Neme end Address of Fecility 23a. Part f. Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Finel NON-HODGICINS LYMPHOMA diseesa or condition resulting in death) Examiner Sequentially list conditions, if eny, leeding to Immediate causa. Entar Underlying Cause (Disease or Injury that initieted events rasulting in deeth) Lest Due to (or es e consequenca of): Physician/Medicai Due to (or es e consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. CORONARY ARTERY Completed HEART Be 25. Wes case raferred to medical examinar? 26. Plece of Deeth (Check only one) Hospitel: 2 1 Yes 2 No 1 2 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury et Work? 28b. Tima of 5 Panding Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, straet, factory, office building, atc. (Specify) 4 Homiclda

3. Time of Death 010 PM 4b. City, Town, or Location of Deeth 4c. County of Death BALTIMORE 8. Data of Birth 9. Birthplace (Stete or Foreign JUN 16 1916 SOUTH CAROLINA 10d. Inside City Limits YYes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - Amarican Indien, Bleck, Whita, etc. Specify: BLACK 16b. Kind of Business/Industry JANITORIAL 20c. Location - City or Town, Stete 3-6-98 | BALTIMORE, MARYLAND WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE 5-64RS 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings eveileble prior to completion of cause of daath? 24a. Was an autopsy performed? 1 Yes 2 2 No 1 Tyes 2FTNo Other: 4 Nursing Home 5 Residanca 6 Othar (Specify) 28d. Describe how injury occurred

29d. Date signed (Month, Dey, Yeer)

Registrar

Medical

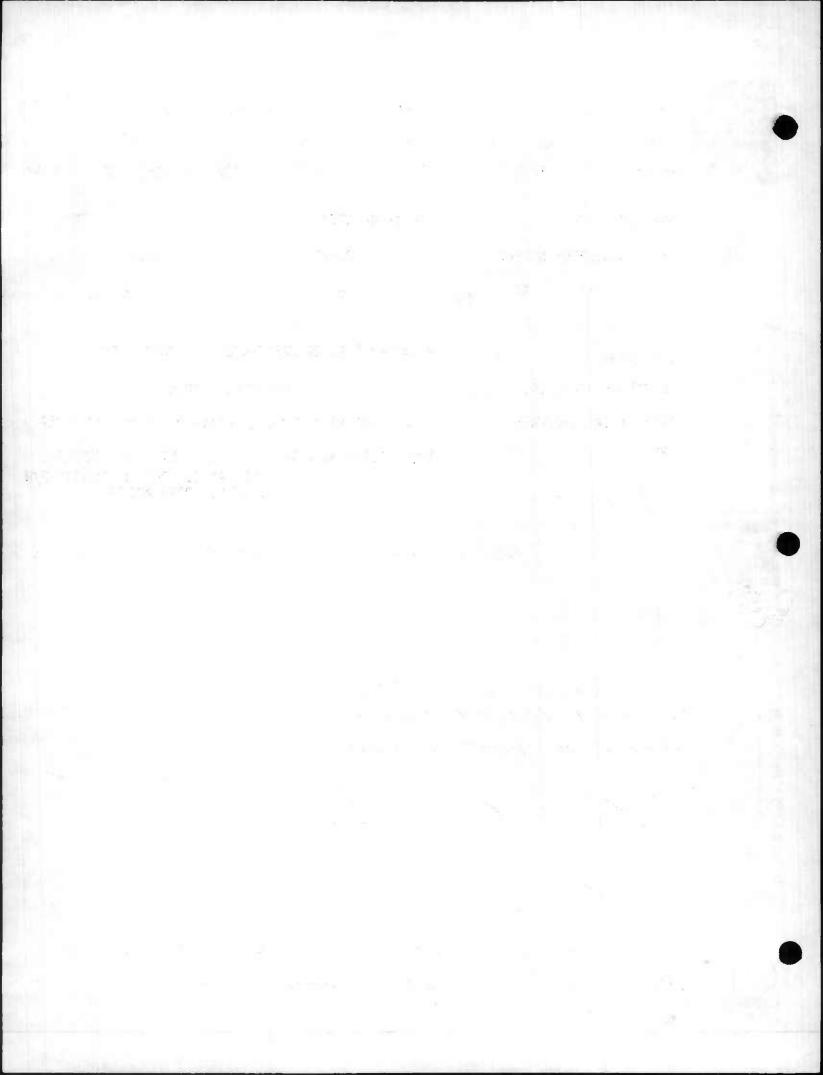
29a. Cartifiar

29b. Signature end title of certifier

BON SECOURSS HOSPITAL, BALTIMORE July Jandon Kington 31. Dete filed (Month, Day, Year) MAR 1 0 1998

nicion

30. Nama and address of person who completed cause of deeth (Itam 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Tima of Death **Physician** Month Am Aa. Facility Nama (If not institution, giva street and number) Knoc Ket 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kernan Baltimore

If Under 24 Hrs. 8. Date of Birth
Hours Min. 8. Date of Birth
(Month, Day, Year) Drive 5. Social Security Number If Under 1 Yaar 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11 M 2 F Months Days Yrs. 215.12.0272 Director 80 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at 1 Yas 2 No Director MD Salti more 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Wrive 2003 21207 USA Funeral ernan 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Spacify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0020 1□ Yes 22No Specify: Black þ 3₽Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important if item 27 is merked other than "n any injury or other traumatic evant. In exercise. Elementery/Secondery (0-12) College (1-4or 5+) GRADE NA WELDER BETHLEHAM 911-1 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Knocket mary Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER 2003 BALTO KERNAN NEATHA WILLIMAN MD 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1-Burlal 2 Cremation 3 Removal from State Balto Courty 3-9-98 4 Donation 5 Other (Spacify) Arbutus 21. Signature of Funeral Se 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Part 1. Enter the dighasa, or complications that causad the death Do not enter the mode of dying, such as cardiac or respiratory arrest, whock or heart tenura. List only one causa on each line. 21229 **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es e consequenca of) 2 2 requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. P.O. 23b. Did tobacco usa contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy performed? Completed peen page 2 certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Hospital or Attending Physician: 24 hour affo death. Purers Director After this certification of the contribution of the contr 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home ome 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred 1 Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 1 Naturel
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29a. Certifier To the To the Complete

State Registrar

31. Date filed (Month, Day, Year)
MAR 1 0 1998

29b. Signature and title of cartifier

GUTHN OAL JAME: DUNLAY 32. Registrar's Signature

MO

(717

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. Licensa number

BUENYE

29d. Data signed (Month, Day, Year)

2/207

and the same of th

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** LEON M MARCH 8, 1998 3:15am /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner GENESIS ELDERCARE - BRIGHTWOOD BROOKLANDVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Securify Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 217-03-6996 82 Yrs. MARYLAND **Director** JULY 3,1915 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at 1 Yes 2 □ No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6317 PARK HEIGHTS AVE, APT. 203 21215 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Hem 27 is marked other than "natural", or Hems 23. Funeral USA 12. Was Decedenf Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☑ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) LADIES SHOES WHOLESALE DISRIBUTOR
18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be marked LEON L. KATZ FLORENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MRS. ANN M. KATZ (WIFE) 6317 PARK HEIGHTS AVE, APT. 203 BALTO., MD 21215 item 2 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify BALTIMORE HEBREW 3-9-1998 BALTIMORE, MD 21. Signature of Emeral Service Company 22. Name end Address of Facility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208 mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Deeth or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest **Physician** Ynen monig /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Physician/Medical Examiner physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as e consequenca of): Division of Vital Records, P.O. Box 687 that the death certificate 88 980 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 200 à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed certificate has t 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: 1 Inpatienf 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this funeral 28b. Time of 28d. Describe how injury occurred 27. Menner of Death 28a. Date of Injury (Month, Dey Yeer) 28c. injury et Work? Certification: 1 Natural 5 Pending investigation 1 Tyes 2 No death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 n 24 hours after ne Funeral Direct pletaly filled in b 4 Homicide VS Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end menner stated. 29a. Certifier Medicai (Check only one) To the Complet

Registrar

31. Dafe filed (Month, Dey, Year)

29b. Signature and title-of cartifier

1/94



30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0 20329

29d. Dete signed (Month, Day, Year)

old Court Rd; Ballimon, no ciros

440 10 1088 860 01 0VII

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth Month MARCH 9 1998 4b. City. Town, or Location of Deeth

/Medical Examiner

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at JEORGE /

ORN

Physician /Medical Examiner

physician s the buriel Box 68760, Records, P.O. peeu certificate Division of Vital this

funeral if or Attending P safter deeth. I Director: After After 24 hours a Hospital within 2 ş

1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth **Physician** George Albert Kornke 04:10 AM 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth TOWSON
If Under 24 Hrs.
Hours Min. BALTIMORE GREATER BALTIMORE MEDICAL CENTER 6. Sex 1 M 2 □ F If Under 1 Year 8. Dete of Birth (Month, Day, Year) March 7, 1898 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months Deys 213-10-1798 100 Yrs Maryland Usuel Rasidence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director Maryland N/A Baltimore City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21214 5611 Plymouth Road United States Funeral 12. Wes Decedent Ever In U.S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2X No þ Specify: 3 Nidowed 4 Divorced White Completed 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantery/Secondary (0-12) Collaga (1-4or 5+) Manufacturing Machinist 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Koski Theodore Kornke Mary 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Susan E. Baier / Niece Joppa, Maryland 395 Enfield Road 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burlal 2 Cremetion 3 Removel from State 4 □ Donetion 5 □ Other (Specify) 3/11/98 Moreland Mem. Park Baltimore, Maryland 21. Signeture of Funerel Service Licensee Michael E. Canapp 22. Name end Address of Fecility Leonard J. Ruck, Inc. 5305 Harford Rd. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or haert failure. List only one cause on each line. PNEUMONIA, BILATERAL Immedieta Ceusa (Final disaasa or condition resulting in daath) IWEEK Dua to (or es a consequence of):

C. PIFFICILE ENTERO COLITIS 15 DAYS Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Causa (Disease or Injury that initieted events resulting in death) Lest GASTERU ENTERITIS ZWEEKS Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 kl Unknown MYOCARDIAL INFARCTION þ 24b. Were autopsy findings aveilable prior to completion of cause of daeth? 24a. Was en eutopsy performed? Completed 1 ☐ Yas 2 No 1 Yes 2 No 25. Wes case referred to medical Be 26. Pleca of Daeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Dev Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Control Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one)

29c. License number

00051228

29d. Date signed (Month, Dey, Yeer)

19/98

MD21228

State Registrar

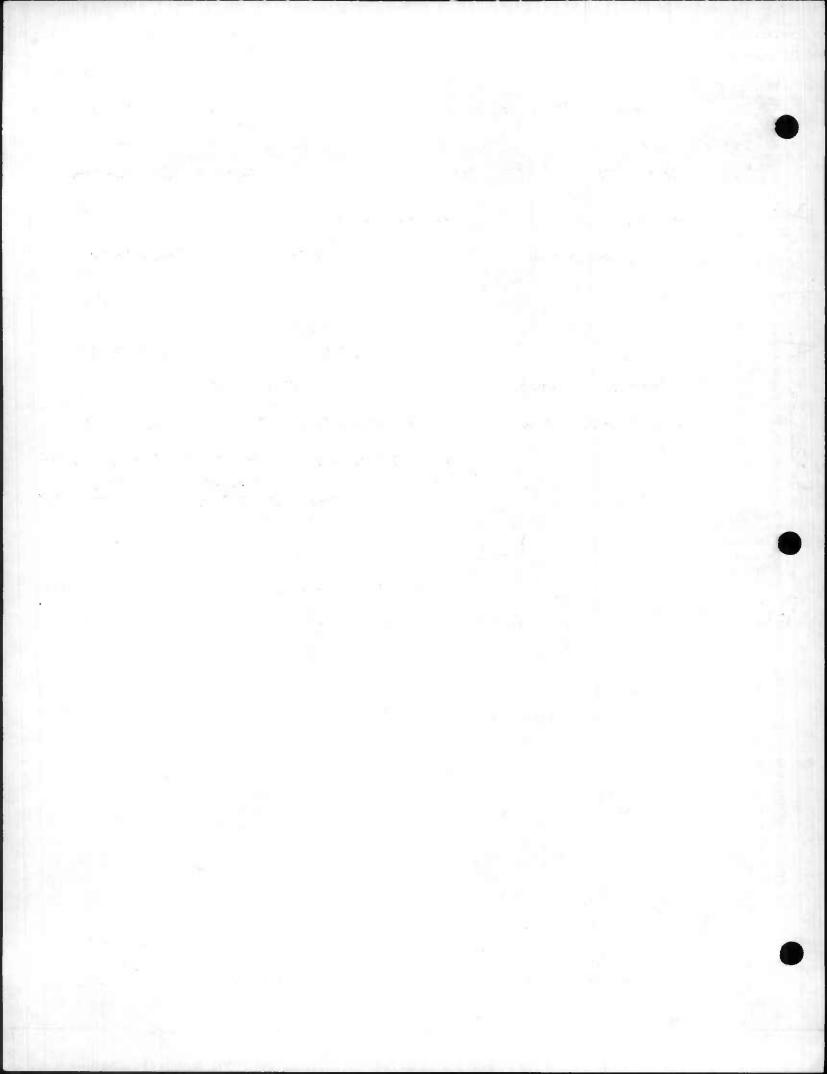
29b. Signeture end title of

31. Dete filed (Month, Day, Year)

30. Name and eddress of person who completed cause of daeth (Itam 23a) (Type, Print)

RAMANA COPALAN MD 2 WEST ROLLING CROSS ROADS #108 RAMANA GOPACAN MD 32. Registrar's Signature Julia Davidson Randall

RAMANA GOIALAN MD



State of Maryland / Department of Health and Me

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Hygiene	8	U	14	J	1

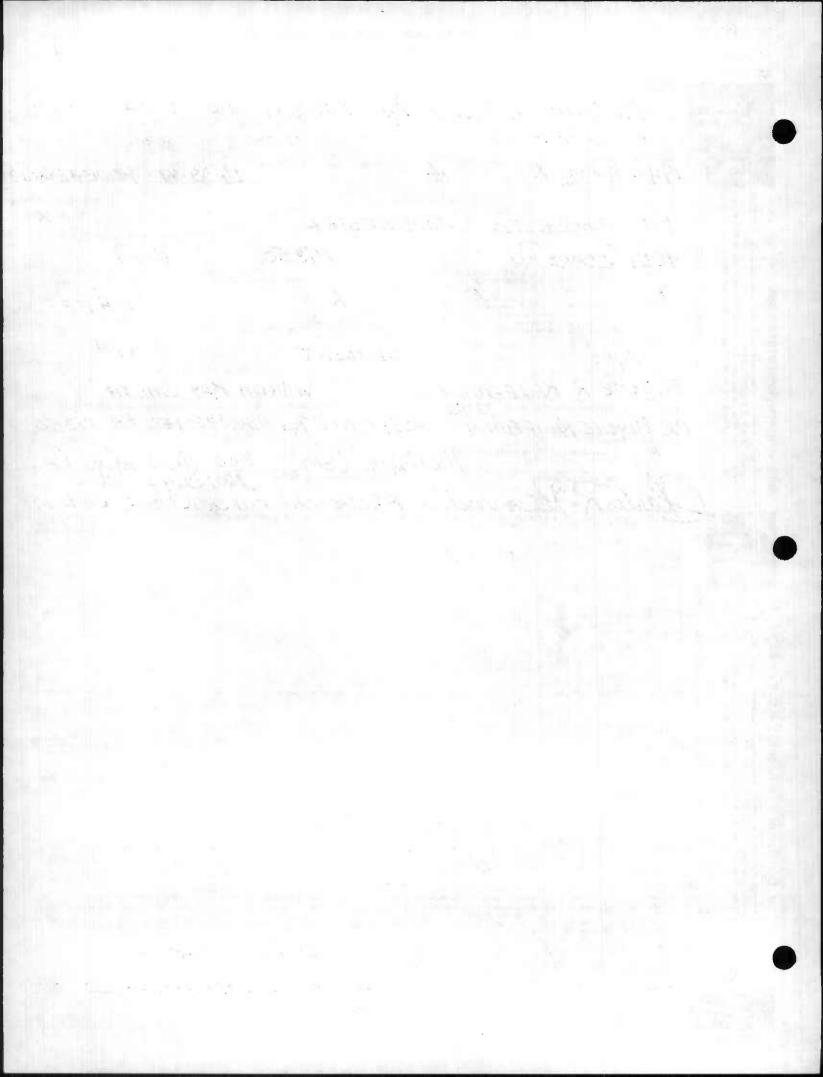
Mental Hygiene	0	0 1	3	0	
Reg. No.					

KAUFFMAN			Certificate of	Death		Reg. No.		
Physician	1. Decedent's Name (First, Middle, Last)	EUGENE	Kauff	man	2. Date of Dee Month MARCH	Day 3, 199	Yeer 8:50P.M	
/Medical Examiner	4e Facility Name (If not institution, give s	street and number)	pecel	4b. City, Town, or L	ocation of Death	-		
(RI)	FALLSTON GENERAL HO		st hirthday) II Under 1 Year	FALLSTO If Under 24 Hrs.		HARF		7 .
Funeral Director	5. Social Security Number 6. Several Security Number 6. Several Security Number 19 19 19 19 19 19 19 19 19 19 19 19 19	M 2 F 7. Age (In yrs. le	Yrs. Months Days	Hours Min.	8. Date of Birt Month, Da	Yeer)	9. Birthplace (State or Fore Country) PENNSYLAVAN	V/
Pull & m	10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Lim	its
ter death with the Maryis items 23s or 28s-1 shother must be notified at Cuneral Director	PA. MANCHE	STER MI	ANCHESTE	R			1 □ Yes 271	No
O ther death with the Ma there aga or 28e.f a siner must be notified Funeral Director	10e. Street end Number	71	10f. Zip Code			10g. Citizen of V	Vhat Country?	
with water	4051 BOARD.	KC		7350	anife Van an Na	20	e - American Indian,	
harra class	11. Meritel Status 1 Never Married 2 Married	12. Was Decedent Ever in U,S Armed Forces?	. 13. Wes Decedent of I If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Blac	k, White, etc.	
Dy Evans	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1□ Yes 2 No	Specify:		Specify	WHITE	
215-0020 Illin 72 hours at a. "natural", or Medical Exam	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Usuel Occu	pation during most of work	rina	16b. Kind of Bu	usiness/industry	
I 21215-0 ied within 72 ho rygiene. we then "naturi it, the Medical."	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire			/	1/A	
nd al Hyg	17. Father's Name (First, Middle, Last)	4		18. Mother's Nam	1)	Maiden Sumen	ne)	
Maryland d 2 should be file file and Mornial by 7 is marked oth traumatic event	EUGENE R. KA	PUFFMAN		WAND	-	5mi	TH	
Mar 12 sh h and ris	19a. Informant's Name/Relationship (Ty	pe, Print) FATHER	19b. Mailing Address (Stree	end Number or Rur	nim 46		0 -	
2000	20a, Method of Disposition	FMHW 20b. Pla	405/DOOR	KO III	Date	STER 20c. Location	17350 City or Town, State	
L Pages 1 treated H tant: If han	1 Burial 2 Cremation 3 R	emoval from State	metery, cremetory or other ple	(00)	3110	VIEW F	Want Pa	
Baltii Separtin Mportar my injur	21. Suppliere of Funeral Service License) lec	22. Name and Addr	ess of Fecility	12011	vinda	16 due	
Physician /Medical Examiner	Fan I. Enter the disease, of complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	Multiple	Injuries	OSK/ /-(ing, such as cardiac	JKERP or respiretory as	CY lom	Approximate Intervel Between Onset end Deeth	۵
ةِ المسلمان		Due to (or	as a consequenca of):					
an and rai-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):					
68760 ficate be g physician as the burn	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	as a consequenca of):					
P.O. Box at the death cert d by the attendin etached for use		I						
D.O. Et the dear thy the att tached to thy sicil	Pert II. Other significent conditions con	tributing to death but not resul	ting in the underlying cause g	ven in Part I.	23b. Dld	lobecco use co	ntribute to the cause of dea	ıth?
					10	Yes 25 No	3 Probably 4 Unkn	owr
nequires been sign should be		1 = 4 = 13				an autopsy med?	24b. Were eutopsy finding evallable prior to completion of cause of deeth?	
I Rec The law ate has t page 2 s					192	Yes 2□No	1 19 Yes 2 No	
Vital I sician: The certificate rector, pay	25. Was case referred to medical			26. Place of Dea		15.0	14,100 22,110	
	examiner? 15XYes 2 No	lospital: 1 Inpatient 2 2 E	R/Outpatient 3 DOA	hor		denca 8 □Oth	er (Specify)	
In P P P P P P P P P P P P P P P P P P P	27. Manner of Death 1 □ Natural 5 □ Pending 2 ੴAccident investigation	28e. Date of Injury (Month, Dey Year) 3-3-99	28b. Time of Injury 20 1 8 M 1 1 C	ry at ork?] Yes 2 ⊠No	28d. Describe	how Injury occur		
Division of the or Attending P at a first death at Director: Affect in by the forest Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At horn building, etc. (Specify)	ne, farm, street, factory, office			Street end Numb vn, Stete)	per or Rurel Route Number,	
Hospi A hou Funer linky till		sician: To the best of my knowner: On the basis of examination and manper stated.	ledge, death occurred at the t		and due to the			
To the Hos within 24 h To the Fun completely		M	29c. Licen	se number		29d. Date signe	d (Month, Day, Year)	
1	1	14	0	.C.M.E.	N	MARCH 5,	1998	

Registrar

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



DHMH 16 Rev 6/95

Physician /Medical	BETTY V. KAI	RATZAS				MARCH	6, 199	Year 11:45a
Examiner	4a Facility Nama (If not institution, give streat e			4	b. City, Town, or ESSEX	Location of Deeth	4c. County	of Deeth
Funeral Director	5. Social Sacurity Number 213-26-9811 6. Sax	7. Aga (In yrs. las		Undar 1 Yaar onths Days	If Undar 24 Hrs Hours Min	8. Data of Birth		9. Birthplace (State or Foreign Country) WestVirginia
death with the Maryland ms 23a or 28a-f show count to notified at	Usual Residence of Decedant 10e. State Md. 10b. County Baltimore	10c. City,	Town or Location		ssex			10d. Inside City Limits
ath with the Marylen 23s or 28s-f show and be notified at real Director	10e. Street end Number 815 Creek Drive	1.	1	10f. Zip Code	21221	1	0g. Citizen of V	Vhat Country?
urs eftar death v il', or flams 23a marstret muni by Funeral	11. Marital Status 1 Never Married 2 Married	s Decedent Ever In U,S. ned Forces? Yes 2 12 No es, Give ar or Dates:		Decedent of Hi s, specify Cuba Yas 2 XNo	spanic Origin? (s n, Mexican, Puer Specify:	Specify Yas or No- to Rican, etc.)		e - American Indian, k, White, etc. White
nature nature		leted)	(Give kind life. DO	's Usual Occupe d of work done o NOT use retired epresen	luring most of wo)	rking		esiness/Industry
ld be filed with ental Hygiene, ked other that ic event, the O Be Comi	17. Fether's Name (First, Middla, Last)		AVOIL	epi eseii	18. Mother's Na	me (First, Middle,	Meiden Sumem	Θ)
s 1 and 2 should be filed within Fleatith and Mental Hygiene. Item 27 is merked other than other traumatic event, the Mercambian To Be Completed to the Mercambian Complet	Walter H. Bowers Sr 19a. Informant's Name/Relationship (Type, Pri Walter Bowers Jr./bro	nt)			and Number or F	Marguerit wal Route Numbe sterstown	r, City or Town,	Stete, Zip Code)
permit. Pages 1 er Department of Hea Important: If Item 2 any Injury or other ance.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donetion 5 ☐ Other (Specify)	сеп	ce of Disposition netery, cremato ly Hill	on (Name of ony or other plec Cemete	e)	Date 9/98		City or Town, Stata
death certificate be axecuted e ettanding physicial and for use as the burdi-transit sician/Medical Examiner	23a. Part1 Enter the diseese, or complications shock, or heart feilure. List only one ceus Immediate Ceuse (Final diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last d	Due to (or a		ty I the Ca		a correspiretory en		Approximate Interval Batween Onset and Death
D 0 0 0	Part II. Other significant conditions contribution MCShlo	g to death but not resulting		rlying cause give	en in Part I.	23b. Did to		ntribute to the cause of death
						24a. Wes e perfor		24b. Were eutopsy findings available prior to completion of cause of death?
ician: The law certificate hes rector, page 2	25. Wes case referred to medical				26. Place of De	1 ☐ Y		1 Yas 2 No
this ald	exeminer? 1 Yes 2 No Hospital 27. Manner of Death 1 Natural 5 Pending 2 Accidant invastigation	1 ☐ Inpatient 2 ☐ EF	8b. Time of Injury	DOA Other	4 L Nursing	Home - Resid		
To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer. Medical Certification:	3 Sulcide 6 Could not be determined 28e.	Place of Injury - At hom building, etc. (Specify)	e, farm, street,	factory, office		28f. Location (S City or Tow	treet and Numb n, Stete)	er or Rurel Route Number,
he Hospi in 24 hou he Funer pletely fill	29a. Certifier (Check only one) 1 ★ Certifying Physicien: 2 ★ Medical Examiner: On an			igetion, In my of	olnion, deeth occ	urred at the time, o	late end place,	end due to the cause(s)
within to the man within	29b. Signature and titla of certifier Sweet Market	mym	1	29c. License	8598		3/6/0	d (Month, Dey, Year) TS
State	30. Neme end eddress of person who complete Shalow Milwin 31. Dete filed (Month, Dey, Year)	d cause of deeth (Item 2		stern	BIV	a 218	121	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

a seve to the line of the second All and the second of the first the second of the second of the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death KNOX Month 1015 pm BERNICE MAR 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE SECOURS HOSPITAL 7. Age (In yrs. lest bjrthday)

Yrs. If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplece (Stete or Foreign Country) 217-24-2963 1 M 2 F Days Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10 Yes 2□No MARYLAND 10e. Street end Number 10g. Citizen of Whet Country? STREET USON USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK 3 ☐ Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mentery/Secondary (0-12) College (1-4or 5+) FOOD SERVICE 11 THGRANE DEPARTMENT STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) EARL JOHNSON JEANETTE 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1327 E. 35THSTREET BALTIHOREMD. 21218 STEVEN SON 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State DRUID RIDGE CEMETERY 3-12-98 PIKESVILLE, MARILLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME 230. Pert1. Enter the disease, or complications that caused the glath. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximate

Approximate Approximete Intervel Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) Due to (or es e consequence of): Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth?

Physician /Medical Examiner

signed by the

this cartificata

Hospital or Attending Physician: 24 hours aftar death.
Funeral Director: After this cardilicately filled in by the funeral director, t

To the Hospital within 24 hours a To the Funeral C completely filled

Completed by

Be

Certification: To

Medicai

Physician

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Examiner

10a State

Funeral

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28a-f show

items 23a

"natural", or

and Mental Hygiena.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Nem 27 is marked other any injury or other traumatic event

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records.

of Vital

Division

Director

Funeral

by

Completed

Physician/Medical Examiner Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last the

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

1 ☐ Yes 2 DNo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 No

25. Was cese referred to medical examiner? 1 Yes 21 No 27. Manner of Deeth 2 Accident

3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation 6 Could not be determined

Date of Injury (Month, Day Year) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

una Davidson

Hospital: 1 I I I npatient 2 ER/Outpetlent 3 DOA 28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier

29c. License number

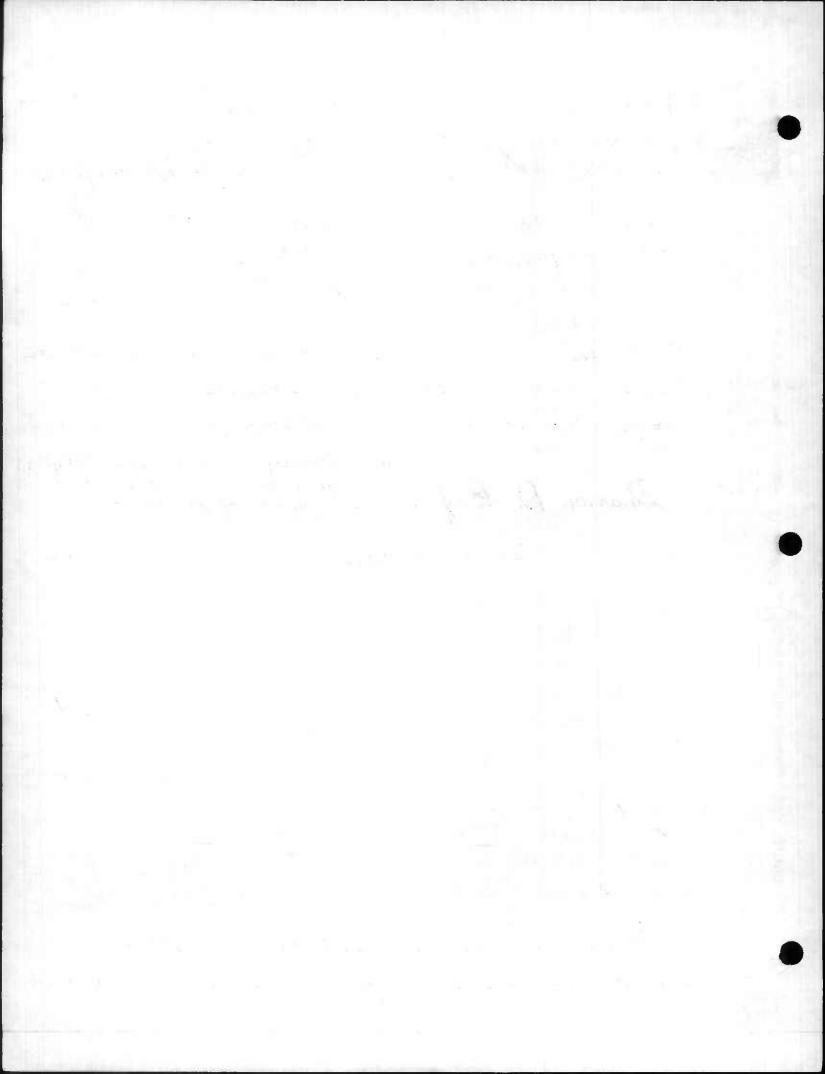
29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

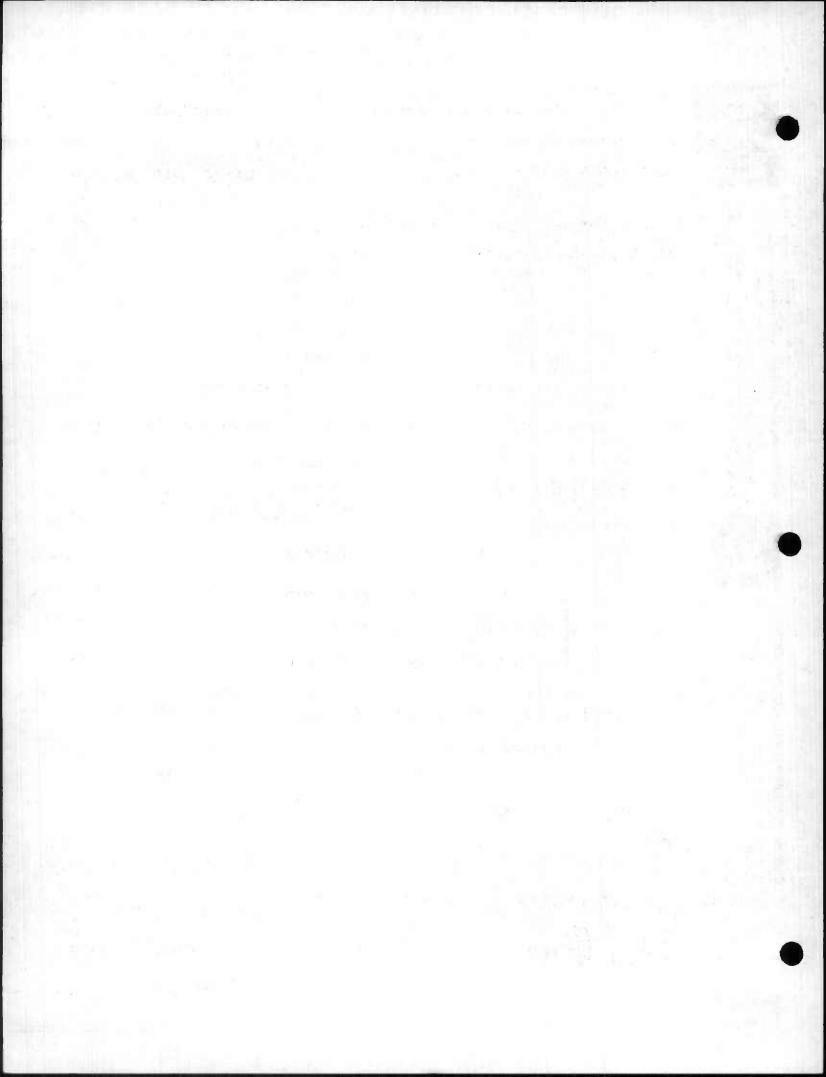
30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

KR154NAN 82 EV7AW ST # 365 BALTIMORE 31. Date filed (Month, Dey, Year) MAR 1 0 1998 32. Pegistrer's Signature

State Registrar



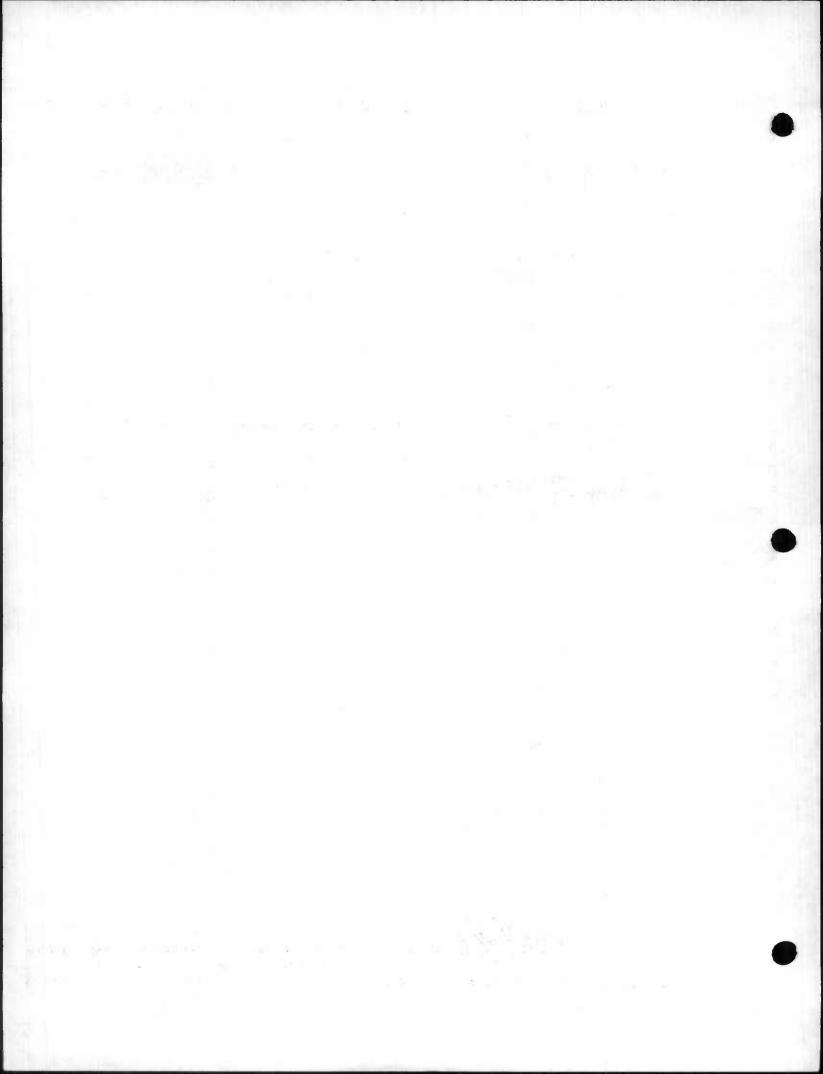
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th the	or 28a-f	lrec	10e. Street and Nu	mber				10f. Zip Coda			10g. Citizen of N	What Counti	ry?
ath wi	238	ral	8375 Ta	mar Dr	. Apt.	615		21045	5		USA		
5-0020 72 hours efter death	d other than "natural", or items event, the Medical Examiner m	by Funeral Director	11. Marital Status 1 ☐ Navar Marr 3 ☐ Widowed		Armed Fo	Ve	U,S. 13.	Was Decedant of Hif Yas, specify Cub 1 ☐ Yas 2 ☒ No	dispenic Orlgin? (Sp an, Maxican, Puarto Specify:	pecify Yas or No Pican, atc.)	Specify	a - Amarica ck, Whita, a Whi	tc.
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ld be	marked other to umatic event, th	To Be	De	nton L	ivenspa	rger				ma UNK			
- CI W			19a. Informant's N	ame/Ralationsh	ip (Type, Print)		19b. Mail	ing Address (Street				State, Zip (Coda)
6 =	If item 27 or other tr		Carol A.		parger/wi	fe	8375	Tamar Dr	. Apt. 61				
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Balt permit.	any ir		,	TIMON	NINICI	Umai		romation	Sociator	of Mary	land, In	nc.	
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O. B	he ette	Physician/M	Part II. Other signif	cant condition	e contributing to d	eath but not re	asulting In tha u	undarlying causa giv	ven in Pert I.	23b. Dld	tobacco uea co	ntribute to	the cause of death?
S, P.O	been signed by the ettandin should be detached for use	by Phy		malis	rant	mis	raine	Jyno	Irone	10	Y00 2 2000	3 Probe	ably 4 Unknown
of Vital Records, Physician: The law requires the	60 CA	Completed			Servin	DIS	oseler			24a. Was parfe	an eutopsy omed?	com	ra autopsy findings ilabla prior to opletion of cause eath?
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To the Hospital or Att	To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one)	1 Certifying 2 Medical E	xaminer: On the b	best of my kr asis of axamir ner stated.	nowledge, deat netion and/or in	h occurred at the tin evastigetion, in my o	ma, data and placa, opinion, death occur	and due to the red at tha tima,	cause(s) end mo deta and place,	enner es ste and dua to t	itad. tha cause(s)
Tot	Com	Σ	29b. Signeture and	title of ogrants				29c. Licans			29d. Deta signe		ay, Year)
			30. Name and alddr	an of person w	MD no complated caus	o of death (to	am 23a\ /Time	- T	654		march	-	998
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State of Maryland / Department of Health and Mental Hygiene

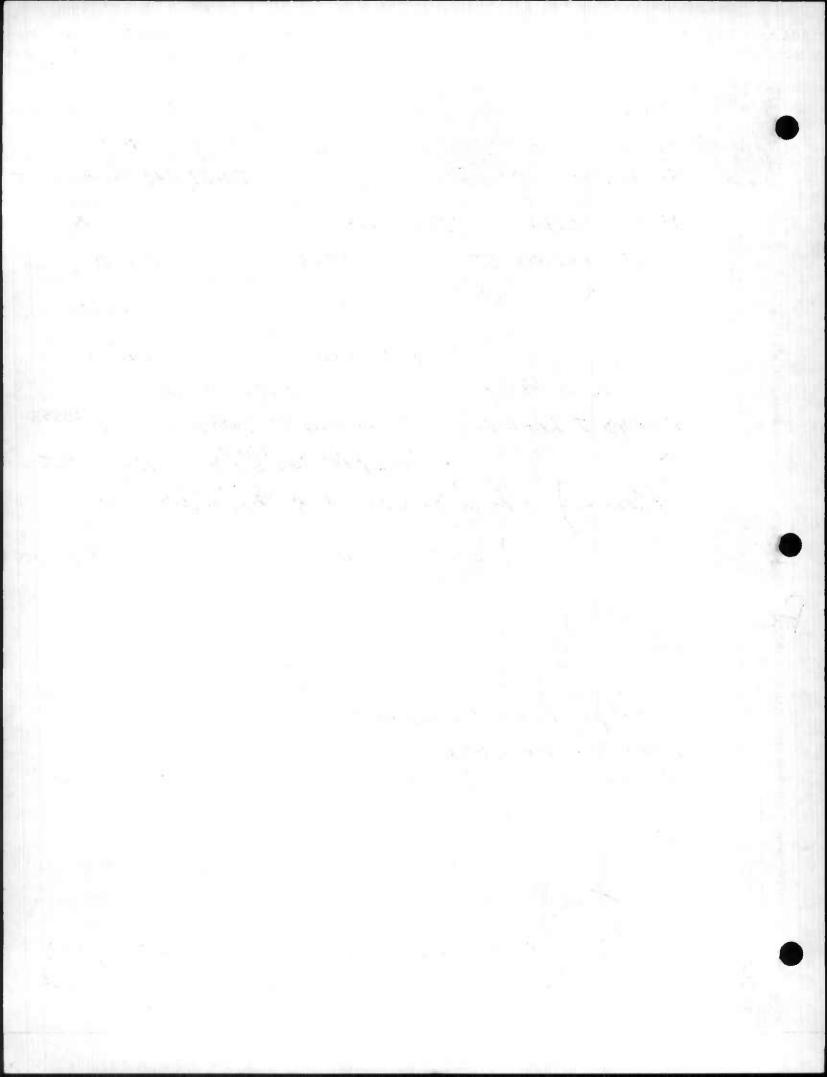
					,	Cei	tificate of	Death		Reg. No.		
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	Physici /Medi		ALIBE	スア		2	EW/S		MARCH		1998	6:50A.
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			Liberty Medica	1 Center				Baltim			N/A	
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	and w		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, 7	Fown or Lo	cation				10	d. Inside City Limits
	the Marylar r 28a-f show	ctor	MD N/A		В	alti	more					1 ☑ Yes 2 ☐ No
	th with th	Funeral Director	10e. Street and Number 323 N. Deniso	n Street			10f. Zip Code 2122	29		10g. Citizen of USA		ry?
5-0020	72 hours after death with the Maryland natural', or items 23a or 28a-f show sical Examinet must be notified at	by	11. Maritel Stetus 1☐ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced	12. Wes Decedent Armed Forces 1 Yes 2 1 1 Yes, Give Yeer or Detes:	Ever in U,S. No		Nes Decedent of f Yes, specify Cul I ☐ Yes 2☐ No	Hispenic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ce - America ck, White, e y: Blac	tc.
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Maryland	d 2 should be file th and Mental Hy 7 is marked othe traumatic event,	2	John Lewi		ī					Foster		
Mar	2 sh and ls m		19e. Informent's Neme/Reletionship	(Type, Print)		19b. Meilir	ng Address (Stree	t and Number or Ru	re/ Route Numbe	er, City or Town	Stete, Zip (Code)
	드등이노		Mary E. Umphery/o	laughter		6 Un	ion Hall	Ct. Cato	nsville	, MD 21	2.2.8	
ore	f of H If iter or oth		20e. Method of Disposition 1 □ Buriel 2 XCremetion 3	Removei from State	00.00	e of Dispo letery, crem	sition (Neme of netory or other pla	ece)	Dete	20c. Location	City or Tov	m, Stete
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Baltimore,	permit. Pages 1 a Department of Har Important: If item eny injury or othe		21. Signeture of Fundous Service Us Dawn F. McDon	mcRo	nalol	C1	Neme end Addr Cemation	ess of Fecility Society of Rd. 1	of Maryl	land, Ir	nc.	
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	Examiner		resulting In death)	e. 131	Due to for e	S B CODSOC	mence off.	EMONIA	04//-1	W. /	9/)	7 20/3
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Box	eath ce attendia for usa	by Physician/I										
	the a	/sic	Pert II. Other significant conditions	contributing to death b	out not resulting	ng in the ur	nderlying cause g	iven in Pert f.	23b. Dld 1	tobacco use co	ntribute to	the cause of death?
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0	arthi arai	L:u	27. Menner of Death	28a. Dete of Inju (Month, De		b. Time of	28c. inju		28d. Describe I			
sion	Aft.	atio	1 ☑Neturei 5 ☐ Pending 2 ☐ Accident investigati		ly rear/	fnjury		Yes 2 No				
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ā	o in in in in in in in in in in in in in	Certification:	4 Homicide	building, et	с. (Бреспу)				City or Tov	vii, Stete/		
	To the Hospital or Attending Phys within 24 hours affector: Affar this To the Funerel Director: Affar this completely filled in by the funaral di	edical (29e. Certifier (Check only one) 1 Certifying F	hysician: To the best miner: On the basis o end manner st	f examinetion	dge, deeth end/or inv	occurred et the t restigetion, in my	ime, dete end plece, opinion, deeth occur	end due to the red et the time,	ceuse(s) end m dete end plece,	anner as sta and due to	ited. the cause(s)
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	1	-	30. Neme end eddress of person who	completed cause of	leeth (Item 2:	3a) (Type	Print) 15	herty 1	nedin	5-1	10/2	5 1-1/8
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	Registr	ar	30. Name and address of person who SUDMRD D 31. Date filled (Month, Day, Year) MAR 1 0 19	98	Davidso	n-Aano	tall					

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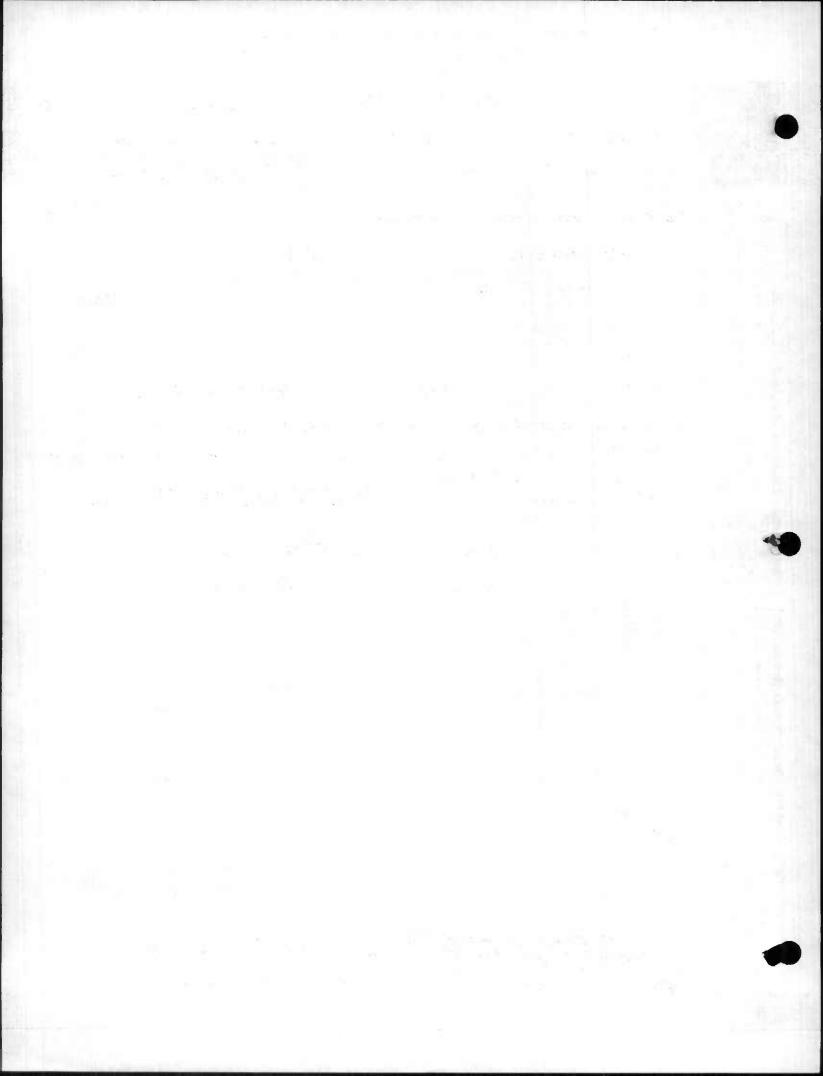
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 7 4 4 2 Certificate of Death Reg. No.

					,	Certificate	of Death		Reg. No.	U	1442
	Obveda		1. Decedant's Name (First, Middla, Last)					2. Data of De Month	ath	Yaar	3. Tima of Death
	Physici /Medi		Karen Ca	endry				Merch	Day 2	1998	2000 HOUA
	Examir		4a. Fecility Nema (If not Institution, giva s	treet and number)			4b. City, Town, o	or Location of Deetl	4c. County	of Death	
1			THE JOHNS HOPKIN	13 HOSI	DITAL		BACTIMI	ORE CITY	/	NA	į.
П	Funeral		5. Social Security Number 6. Sax	M 200 F	a (In yrs. last bir	Months D	ear If Undar 24 H		th v. Year)	Count	laca (Steta or Foreign
	Director		100 72-6579	M 276	50	Yrs.	,	TUN.2	7,1947	MIC	LBURD, NJ
	and w		Usual Rasidance of Decedant 10a. State 10b. County		10c. City, Tow	n or Location			/		Od. Inside City Limits
	Maryland H show	ö	01-	. 1		11				,	1 Yas 2□ No
	the P	ect	N.J. OCEA	U	100	10f. Zip Co	da		10g. Citizen of V	What Count	-
	with the	ō	, ,			101. 2.10 00					M
	death me 23	era	11. Maritel Status	2. Wes Decedent	Ever in II S	13 Was Decedan	753	(Specify Vas or No		e - Amarica	an Indian
	ftar d	Funeral Director	1 Navar Married 2 Married	Armed Forcas? 1 ☐ Yes 2 ☑		If Yas, specify	of Hispenic Origin? Cuban, Maxican, Pu	arto Rican, atc.)	Bled	k, Whita, e	
020	ours efter death with the Marylar sal,, or items 23a or 28a-f show Examiner must be morified as	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yaar or Datas:		1 ☐ Yas 2	No Specify:		Specify	1114	liTE
5-0020	2 should be filed within 72 hours efter and Mental Hygiena. Is marked other than "natural", or ite aumatic event, the Medical Examine		15. Decedant's Educ		16a.	Decedant's Usuei C	ccupation		16b. Kind of Bu	usinass/Ind	lustry
215	hin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Complated) College (1-4or 5	4)	(Giva kind of work of lifa. DO NOT usa r	lona during most of и atired)	vorking			
21	filed with Hygiena. ther than	NO.	12			HOMEMA	KEL		OWN	Hor	YE
pu	be filed tal Hygi d other event, I	Be (17. Fathar's Neme (First, Middia, Last)	11.			18. Mother's N	ame (First, Middla,	Maldan Sumem	a)	
yla	should be nd Mental marked o	To	EDWIN	KELLY			RU	TH M	HHER		
Maryland	permit. Pages 1 and 2 should be filed within Deportment of Health and Mental Hygiena. Important: If item 27 is marked other than any Injury or other traumatic event, The Mande.		19e. Informant's Name/Relationship (Type	pa, Print)	19b	. Mailing Address (S	treet and Number or	Rural Route Numb	er, City or Town,	Stata, Zip	Code) CATS 2
	other tr		RICHARD J. L	4NDRY	6	1 LONGI	MAN ST.	181951	RIVER,	Ni	7. 00/03
ore	f of H		20a. Mathod of Disposition Buriai 2 Crametion 3 R	movel from State	20b. Placa o camara	f Disposition (Nama ry, cramatory or otha	of r place)	March	20c. Location -	City or To	wn, Stete
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alt	permit. Par Depertmen Important: any injury		21. Signature of Funaral Sarvice Licansa	a //	11	22. Nama and A	ddrass of Facility	1829 14	Depen	57.	, N.T.
Ш	20129		Morris 1	Sken	leb.	SKANI	AFH.	Barro	MD.		
			23a. Part1. Entar tha disaase, or complice shock, or haart failura. List only on	ations that causad	tha death. Do	not antar tha moda o	dylng, such es card	iac or raspiratory a	rrest,		Approximete
	Physician		strock, or tradit failure. Layonly or	a causa on each iii						1	Intarval Batween Onset end Death
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п	Examiner		rasulting in death) a			consequence of):					1- 10000000
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)_1	cete be executed only sician and the buriel-transit	Examiner	Sequentially list conditions,		Due to (or es e	consequance of):					
g	cian s		Sequantially list conditions, if eny, laading to immedieta cause. Enter Undarlying Causa (Disaasa or injury								
68769	icete be es physician s the burie	de	that initiated avants rasulting in death) Last		Dua to (or as a	consequance of):					
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Вох	that the death ceied by the attendir detached for usa	lan									
	the de	ysic	Pert II. Other significant conditions con	ributing to death bu	it not rasulting in	n tha undariying caus	a givan in Part I.	23b. DId	lobacco uaa coi	ntribute to	the cause of death?
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or	been si should	tec	tolucuthem	ra /	eva			24a. Was perfo	an autopsy rmed?	ava	ra autopsy findings allable prior to appletion of cause
Records,	has b	Completed	0		1					of d	iaath?
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of	hysle his o	2	1 ✓ Yas 2 ☐ No			tpatient 3□ DOA		Homa 5 ☐ Rasi	dence 8 Oth	ar (Specify)
E C	on of the control of	0	27. Menner of Daath 1 ■ Naturel 5 ■ Panding	28a. Dete of Injur (Month, De)	y Year) 28b.		Injury at Work?	28d. Dascribe	now injury occurs	ed	
Sign	Attending or death. ector: After by the fune	cat	2 Accident invastigation 3 Suicida 6 Could not be			М	1 ☐ Yas 2 ☐ No				
Division	7 = C	Certification:	4 ☐ Homicida detarmined	28e. Placa of Inju	iry - At home, fa . (Specify)	rm, straat, factory, of	fica	281. Location (a	Straat and Numb vn, Stata)	er or Rural	Routa Number,
_	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		On Ontifer all and								
	Hos Fun Fun	edical	29a. Cartifiar (Check only one) 1 ☐ Certifying Physical Check only one)	er: On the basis of	axamination an	i, daath occurred et t d/or invastigation, in	na tima, data and pia my opinion, death oc	ce, and dua to tha curred at tha tima,	ceuse(s) end me data and placa, a	nnar es sta and dua to	atad. tha causa(s)
	thin the sample	N N	29b. Signature and the of pertifier	and mannar sta	tea.	29c Li	cansa number		29d. Data signed	1 (Month I	Day Year)
	F ≯ F 8		b //2/ 1/	11.1	in. 1						
			1/0 M	mura	PULD.		85-00	0	Warch	1 2	11998
	3		30. Name and address of person who cor	.11 1	ath (Itam 23e)	(Type, Print)	85-00 Fe Street	Reli	. M.	1	2/287
		•	31. Dete filed (Month, Day, Year)	77a M. ()	r's Signatura	vorth Not	re street	1-0/4m	ou l'ay	1/aprel	acra or
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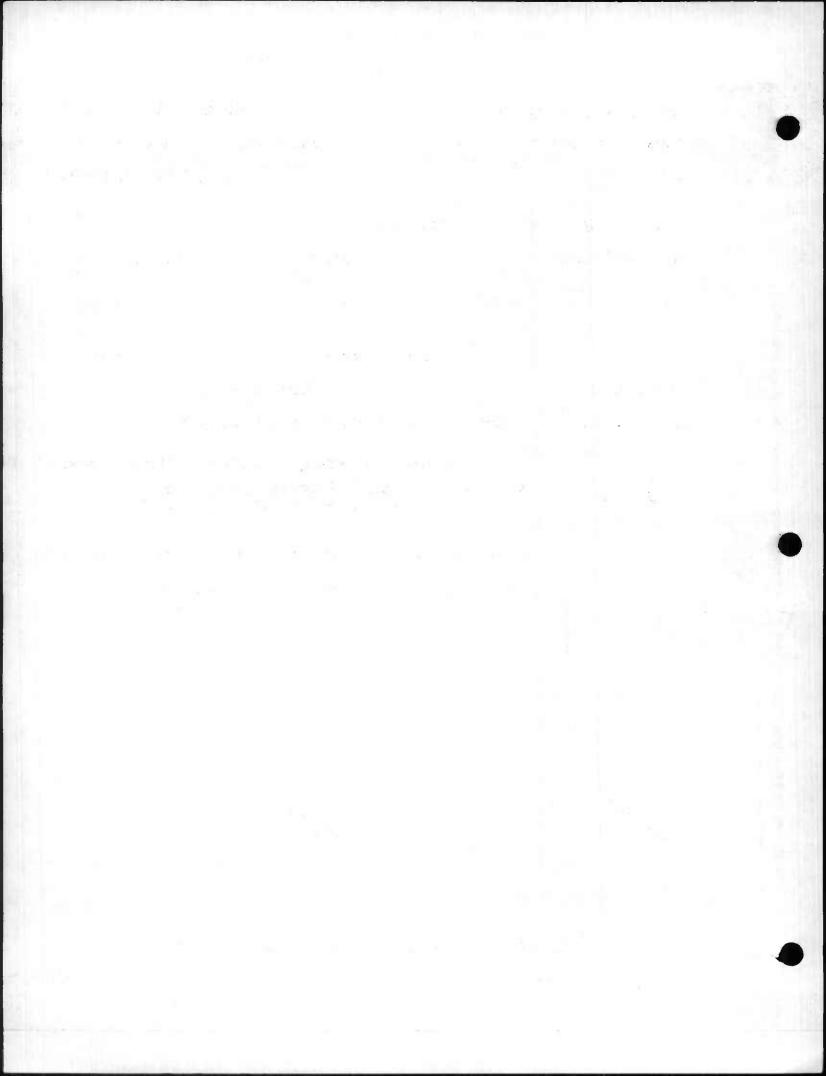
State of Maryland / Department of Health and Mental Hygiene 8

					00.	tificate	Or Doutin		Reg. No.		
Physicia /Medic	an	1. Decedent's Name (First, Middle, La	LOU	IS N	ŒLVIN	LACE	?	2. Date of Dec Month March	Day	Year	Time of Death 5:40 Ph
Examin	_	4e. Facility Name (If not institution, giv		r)			4b. City, Town, or	Location of Death			
		7825 Acorn Ban	k		21122		Pasaden		Anne	Arunde:	L
Funeral Director		213-34-7108	Sex 7./	199 (In yrs. 60	last birthday) Yrs.	If Under 1 Months	Year If Under 24 Hrs Days Hours Min	(Month, Da	h y, Year) 17, 193	9. Birthplace Country) 7 Mary	(State or For Land
*	-	Usual Residence of Decedent 10e. Stete 10b. County		10a Cit	ty, Town or Loc	nation					14 00 11
28a-f ahow			Arundel	100. Ci	Pasadei						nside City Li I □ Yes 2€
28a-f	ecto	4	Arunder		rasauei						103 26
23a or 3	Funeral Director	10e. Street and Number 7825 Acorn	Bank			10f. Zip C	21122		10g. Citizen of V	What Country? USA	
o, o	by	11. Meritel Stetus 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Tyes 276 If Yes, Give Year or Detes	?] No			nt of Hispanic Origin? (5 Cuben, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	e - American II ck, White, etc.	
natural',	ted	15. Decedent's Ed (Specify only highest gra	ducation		16e. Deced	ent's Usual	Occupation	utina	16b. Kind of Br	usiness/Indust	у
	Completed	Elementery/Secondery (0-12)	College (1-4o	r 5+)	life. D	O NOT use	done during most of wo retired)	rkary			
t of Health and Mental Hygiena. If item 27 is marked other than or other traumatic event, the M	8	9	0		Se	electo	or		U.S. F	ood Ser	vice
nd Mental Hyg marked other imatic event,	Be	17. Father's Name (First, Middle, Last,)				18. Mother's Na	me (First, Middle,	Maiden Sumen	ne)	
and Mental H Is marked of raumatic eve	0	Leroy	н.	I	acer		Sop	hie E.	Conwa	У	
and le m		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	g Address (Street and Number or A	ural Route Numbe	er, City or Town,	State, Zip Coo	fe)
er tr		Virginia A. Lac	er (wife		7825	Acor	Bank, Pas	adena, M	arvland	21122	2
of He rest	1	20a. Method of Disposition			Place of Dispos	ition (Name	of	Date	20c. Location -	City or Town,	State
at: #		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		8			ematory Mai	9, 199	7 Balti	imore,	Marv1
Department of Her mportant: If item any injury or othe ance.	-	21. Signature of Funeral Service Licer					Address of Fecility				1 1
Depar Impor		NX VI		D. D	CINCI		11y-Polynia E. Fort Ave	ak Funera	al Homes	21230	
		23a. Part1. Enter the disease, or com shock, or heart feilure. List only	plications that caus	ed the deet	h. Do not ente	r the mode	of dying, such es cardia	c or respiratory ar	rest,	App	oroximate orvai Betwee
ysician Medical aminer		Immediate Cause (Finel disease or condition resulting in death)	a	Due to (c	Has a consequence	the uence of):	Pane	near			
Chranet	Examiner	Sequentially list conditions,	b	Due to (c	or as a consequ		2	Ny			
		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events	c	Directo (e							
ding phy se as th	Medi	resulting in death) Lest	d	Due to (o	r as a consequ	ence or);					
ed by the attandir datached for use	Physician/										
ched	ysi	Part II. Othar significant conditions o	ontributing to death	but not res	ulting In the un	derlying cau	se given in Pert I.		obacco use co		
igned by be datac	by Ph							10	Yes 2 No	3 Probabi	y 4□Uni
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should	e e							perio			h7
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ate has been s page 2 should	Completed	25 Was core referred to medical						101	es 2 No	1□Ye	_/
ate has been s page 2 should	Be	25. Wes case referred to medical examiner?	Hospital:				Other:	ath (Check only o	ne)	1 □ Ye	_/
ate has been s page 2 should	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa		ER/Outpatient		Other: 4 Nursing	ath (Check only o	ne) lenca 6 🗹 Oth	1 □ Ye	_/
ate has been s page 2 should	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D		ER/Outpatient 28b. Time of Injury	28	Other: 4 Nursing I	ath (Check only o	ne)	1 □ Ye	_/
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ate has been s page 2 should	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of In (Month, L	jury lay Year) njury - At he etc. (Specif	28b. Time of Injury ome, farm, stre	M 284	Other: 4 Nursing I	ath (Check only of Person 1976) ath (Check only of Person 1976) 28d. Describe has been contained at the Person 1976 of Perso	ne) denca 6 ⊡Oth now Injury occur Street end Numb nn, State)	1 □ Ye er (Specify) red er or Rurel Ro	s 252 No
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State of Maryland / Department of Health and Mental Hygiene Q Q

	_	1. Decedent's Nama (First, Middla, Las	sf)		Certit			2. Data of De			3. Tima of Death
hysicia	_	Virginia Evealine	Lawbown					March	9. 1998	Yaar	10:40 A
/Medica Examine	_	4e. Facility Nema (If not institution, give	a street end number)				4b. City, Town, or L				2011071
.xamme	"	Genesis Eldercare	Nursing (Cente	r		Severna I	Park	Anne	Arur	ndel
ineral		5. Social Security Number 6. S			ast birthday) 11	f Undar 1 Year lonths Days	r If Under 24 Hrs.				ace (Stata or Fore
rector	-	215-30-6539 Usual Rasidance of Dacedant	LIM 2LAF	0	4 Yrs.	Daya	riouis wiii.	Jan. 9	1914	W. V	irginia
items 23s or 28a-f show free must be notified at	_	10a. Stata 10b. County		10c. City,	, Town or Locati	ion				10	0d. fnslde City Lim 1 X Yes 2 ☐ I
office	5	Md. N/A		В	altimor	10.0					
200	Director	10e. Street and Number				10f. Zip Code	005		10g. Citizan of V		try?
magt	era	3702 Third Street	12. Wes Decedant I	Ever In 11 G	12 14/00		225	nacihi Van ar Na	U.S.A	e - Amaric	en Indien
PE .	by Funeral	11. Maritai Status 1 □ Nevar Marriad 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forcas? 1 ☐ Yas 2 💢 N If Yas, Giva Year or Dates:			Yas 2 No	Hispanic Origin? (Span, Maxican, Puarto Specify:	o Rican, atc.)	Blac	ck, Whita,	etc.
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vent, I	Be	17. Father's Name (First, Middle, Last)					18. Mothar's Nam	na (First, Middla	, Maidan Sumam	ia)	
arks tic	2	Charles Loyd							yser		
27 is m		19a. Informent's Neme/Raiationship (1) Leona 0'Connell ()			et an <i>d Number or Ru</i> Avenue Bai				
othar	-	20a. Mathod of Disposition	- Judgii voi	•	ace of Disposition			Data	20c. Location -		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Départment of Health and Mental Hygiene 🛭 🦓 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month J. Linton Mar. 4 1998 12:15 P.M. 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Ruxton Nursing Home Towson **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, August 1988) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 3 F 215-10-2229 83 Yrs. April 8, 1914 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits Baltimore Dunda1k 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8103 Parkhaven Road 21222 U.S.A. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - American Indian, Biack, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas: 1 ☐ Naver Married 2 ☐ Married 1 ☐ Yes 2 🂢 No Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 18b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Sales Associate Dept. Store 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Jasinski Mary Popicka 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) John Muth/ Nephew , Timonium, Md. 21093 101 Gorsuch Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore-Washington 3-5-1998 Laurel, Md. 21. Signatura of Funerai Servica 22. Name and Address of Facility Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc. 2134 Willow Spring Rd., Paltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Do not enter the moda of dylng, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final diseasa or condition rasulting in daath) Sequentially list conditions, if any, leading to Immediate cause. Enter Undarlying Cause (Disaase or Injury that initiated events rasulting in death) Last Due Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the causs of death? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2/2 No 1 Yes 28 No 25. Was cese rafarrad to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Rasidence 6 ☐ Othar (Specify) 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding investigation 1 ☐ Yas 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be detarmined

Examiner The law requires that the death certificate be executed pue P.O. Box 68760, physicien the use es for use es P signed b Records, been sig s certificate hes t director, page 2 s ivision of Vital After this Director: After the Attending death.

Physician /Medical

> Examiner Physician/Medical by Be Completed 2 Certification: Medical

4 Homicide

29a. Certifier

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30. Name and adde

31. Date filed (Month, Day, Year)

0 1998

Physician

/Medical

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Director

Funeral

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Completed

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Funeral

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23, any Injury or other traumatic avant

Baltimore, Maryland 21215-0020

with the Maryland

Registrar

State

Tertifying Physician: To the best of my knowledge, daath occurred at tha time, date and place, and due to tha causa(s) and manner as stated.

2 Madical Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and 29b. Signature and title of certifie

29c. Licanse number daath (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

32 Ragistrar's Signatura Tue Davidson-Randace of Book and the St. of the street

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day Vear Edmonia R. Miller 4e. Fecility Name (If not institution, give street end number) March 5 1998 8:00 AM 4c. County of Death 4b. City. Town, or Location of Death Sinai Hospital Baltimore If Under 24 Hrs. Hours Min. Baltimore If Under 1 Year 6 Sex 5. Sociei Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Deys 1 M 2 F 225-42-9204 Vrs 96 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 ☐ Yes 2 Ø No NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3302 KOAD HILLSDALE 21207 USA Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Stetus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 □ Divorcad BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) CITY OF BALTIMORE YEARS SCHOOL 12 TH GRADE EACHER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BROOKS IYREE ALMANDA 19e. Informant's Name/Relationship, (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) SHARON WILSON 3302 GRAND LAUGHTER HILLSDALE BALTO. MD 21207 20b. Pleca of Disposition (Name of cametery, crematory or other place) 20a. Methød of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MEADOW RIDGE CEMESERY 4 ☐ Donation 5 ☐ Other (Specify) 3-10-98 ELKRIDGE, MD 21. Signature of Furieral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SER. 5151 BALTO. NATL' PIKE, BALTO, MD. 21229 23a. Part1. Enter the distance, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Ceuse (Final a Pulmonary Fibrosis WI Pneumonia disease or condition resulting in death) 5 days Due to (or es e consequence of): Due to (or es e consequence of): Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?

Physician /Medical Examiner

pue

Physician

/Medical

Examiner

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Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

the Meryland

filed within 72 hours efter death with

Peges 1 end 2 should be filed within nent of Health end Mental Hygiene. ant: if item 27 is marked other than "

permit. Peges 1 end 2 s Department of Health er Important: if item 27 is any injury or other trau

Baltimore, Maryland 21215-0020

ettending physician for use es the burie Physician/Medicai signed by the et b Completed Be 2 Medical Certification:

or Attending Physician: The law requires that the death certificate be executed

certificate

this

To the Hospital or within 24 hours eft To the Funeral Di completely filled in

Asfon of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 DENo

1 ☐ Yes 20 No

25. Was case referred to medical examiner?			28. Plece of Death (C			
1 ☐ Yes 2 Mo	Hospital:	☐ ER/Outpatient	3□ DOA Other:	4 Nursing Home	5 Residence	8 Other (Specify)
27. Manner of Deeth	28a. Date of Injury (Month, Dev Year)	28b. Time of	28c. Injury a Work?		. Describe how Inj	

2 Accident Investigation 3 Suicide 6 Could not be

4 Homicide

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

150 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) and manner as stated.
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piace, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

AJ4147357KL97/KL/8615 Morch (,1998

30. Name and add of person who completed cause of death (Item 23a) (Type, Print)

240/ W. Belvedere Ave.

State Registrar

Kyle Low, MO 31. Date filed (Month, Day, Year) MAR 1 0 1998

29b. Signature and title of cartifier



And the state of t

Item: 9,10f Per FH Film G-757 3-17-98RC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		Decedent'a Name (First, Middle	Last)		Centil	cate of	Death	2. Dete of Dec	Reg. No.		3. Time of Deeth
nysicia	an	IDA	Last)		MILLE	PD CTS		Month	Day	Yes	7:50 AM
Medic kamin		4e. Facility Name (If not Institution,	give street end nu	mber)	MILL		4b. City, Town, or I	MAR Location of Deeth	4c. Count	- 4	. (- 20 M
		LEVINDALE					BA	LTIMORE		N/A	
neral ector		5. Social Security Number 212-09-1535	6. Sex 1□ M 2□ F	7. Age (In yrs. 86		nder 1 Year oths Deys	Hours Min.	8. Dete of Birth (Month, Det NOV • 28	, Year) B, 1911	9. Birth	plece (State or Foreig
		Usual Residence of Decedent 10a. State 10b. County		10c City	y, Town or Location					WEST	VIRGINIA
ust be notified at	٥		7 / 7	100. 04							10d. Instde City Limit 1 ☐ Yes 2 ☐ N
nottra	Director	10e. Street and Number	I/A		BALTIN	IORE f. Zip Code			10g. Citizen of	What Cou	Λ
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aumatic		19e. Intorment'a Neme/Reletionsh	lp (Type, Print)		19b. Matting Add	dress (Street	end Number or Ru	ral Route Numbe	r, City or Town	, Stete, Zip	o Code)
other tr		MRS. DORIS TAY	LOR (NIE		6317 PA	RK HE	IGHTS AVE				
any injury or oth		20e. Method of Disposition 1		State	lece of Disposition emetery, cremetory ALTIMORE	or other ple		3/9/98	20c. Location REIST		
2000		21. Signature of Funeral Service L	· to	who	SC	T. LEV	oss of Facility INSON & B	ROS., IN	vc.		
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should be det	Completed by							24e. Wes a	an autopsy med?	av cc	ere eutopsy findings vallable prior to empletion of cause
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rector, pag	Bec	25. Was cese reterred to medicel					26. Place of Dea	ith (Check only or			2.00 22.00
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		27. Menner of Death 1≯≅Neturel 5 □ Pending 2 □ Accident investiga	ition	ot Injury th, Dey Year)	28b. Time of Injury M	28c. Injur Wor 1 🗆	y at rk? Yes 2 □ No	28d. Describe h	ow injury occu	rred	
he	ertific	3 Sulcide 6 Could no 4 Homicide determin	ed 200. Place	of Injury - At hong, etc. (Specify	me, ferm, street, fe	ctory, office		28f. Location (S City or Tow		ber or Run	al Route Number,
ed in by the f	O		Physician: To the	best of my know	vledge, deeth occu ion end/or investiga	rred at the tir ation, in my o	ne, dete end place pinion, deeth occu	, end due to the orred et the time, o	euse(s) end m dete end piece,	anner as s and due to	stated. o the ceuse(s)
pletely filled in by the f		29e. Certifier 1 Certifying 2 Medical E	xaminer: On the ba	ner stated.							
	ledicai	(Check only 2 Medical E	xaminer: On the ba	ner stated.		29c. Licens	e number		29d. Dete signe	ed (Month,	Day, Year)
completely filled in by the f	ledicai	(Check only 2 Medical E	xaminer: On the ba	Such	Day Kong	29c. Licens	e number	7	29d. Dete signe	ed (Month,	Day, Year)
completely filled in by the f	Medical	(Check only 2 Medical E	xaminer: On the ba	Such	23e) (Type, Print)	29c. Licens	4575°	7 lerve	MAR. BALI	ed (Month,	Day, Year) 11998 21213

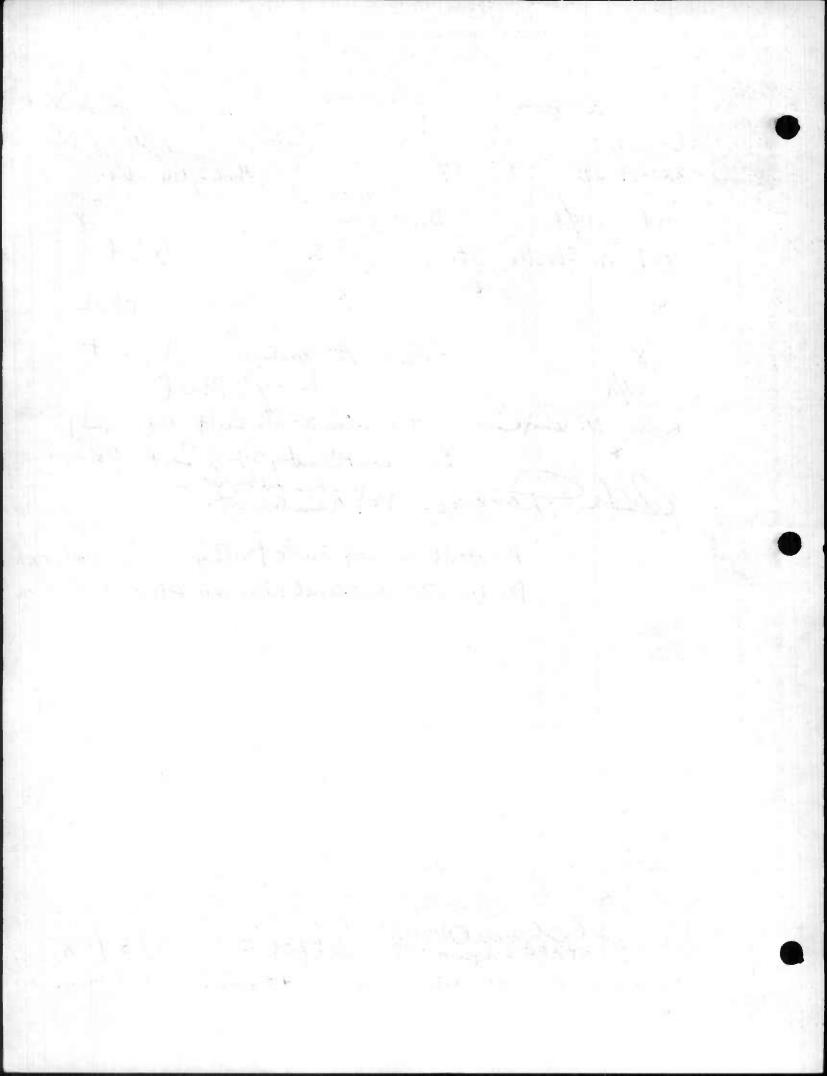
800 111

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Deeth STER ESTHER O. MAY DEN Day **Physician** Month 4.25 /Medical 4a. Escility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County Death Examiner HO1 Salfo Undar 24 Hrs. 6. Sex If Under 1 Yaar 5. Sociel Security Number Aga (In yrs. last birthdey) 9. Bighplece (Stete or Foreign Jountry) **Funeral** Days 1□ M 2 F 220-19-2845 Usual Residence of Decedent Yrs. Director Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland nent of Haaith end Mental Hygiene. nt: if item 27 is marked other than "natural", or items 23a or 28a-f show 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23s or 28a-f show traumatic event, the Medical Examiner must be notified at Balti more 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21231 40 Funeral Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, atc. 11. Marital Status 1 Yes 2 No If Yes, Give Yaar or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 □ Divorced ack Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Work grand 17. Fether's Nema (First, Middle, Last) 2 Informent's Name/Relationship (Type 2123 other t 20b Piece of Disposition (Neme of cemetery, cremetory or other) 20e. Method of Disposition permit. Pages Depertment of I Important: If its any Injury or o 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Approximate intarval Between Onset end Deeth **Physician** /Medical Immediata Cause (Finel diseese or condition resulting in death) Examiner dwodenel ulcer with sefses unknown Examiner law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated avants resulting in death) Lest sata has been signed by the attanding physician and pega 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as e consequence of) Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Tas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings avelleble prior to complation of causa of deeth? Completed 24e. Wes en eutopsy After this certificata has 250 No 1 Yes 1 ☐ Yes 2 ☐ No Attanding Physician: filled in by the funeral director, 25. Wes cese referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth Certification: 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Hospital or Attandi 24 hours after death. Funeral Director: A 2 Accident 3 Suicide 6 Could not be 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. Medical 29b. Signatura and title of pertifier, 29c. Licansa number 29d. Data signed (Month, Day, Year) mue STAFFSWIGEON 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Church Hospoital BACTIMORE MD GURUSWAMY MD GOPAL 31. Dete filed (Month, Dey, Year)

State Registrar

32. Registrer's Signature was widen



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 8:20 p.m. RONALD MICHAELS, SR. March /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner UNIVERSITY OF MARYLAND MEDICAL SYSTEM BALTIMORE N/A Hours Min. 8. Dete of Birth (Month, Dey, Year) SEP 7, 1946 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1√2 M 2□ F 207-34-5717 51 Yrs. Director Pennsylvania Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner maint be notified at PA Perry Newport 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 428 Mulberry Street 17074 USA Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 [AYes 2□ No 1963-66]
If Yes, Give 1963-66 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after c Department of Health end Mental Hygiena. Important: If item 27 is marked other than "natural", or item any injury or other traument. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry Elementary/Secondery (0-12) Cotlege (1-4or 5+) Construction Worker Aluminum Siding 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Charles Michaels Edna Mae Wolfe 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Carol A. Michaels/wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other place)

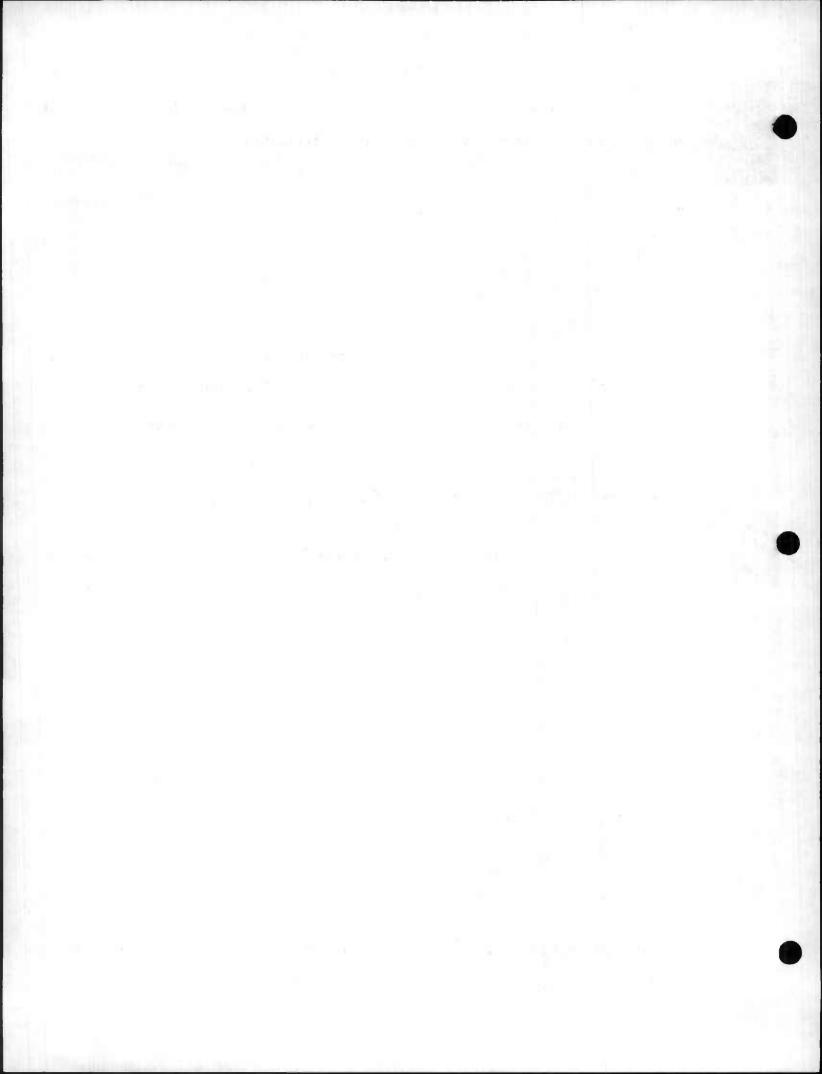
Newport, PA 17074

20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2X Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 03/09/98 Baltimore, MD 21. Signeture of Fugeral Service Licenseem C Omaly

Dawn F. McDonald 22. Name end Address of Fecility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervet Between Onset end Deeth **Physiclan** /Medical Immediete Ceuse (Final END STAGE LIVER CIRCHOSIS disease or condition resulting in deeth) Examiner Due to (or es e consequenca of): ALCOHOLISM The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initieted events resulting in deeth) Lest Due to (or es e consequence of): attending physician for use es the burie Box 68760. Physician/Medical Due to (or es e consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 3 ata has been signed page 2 should be de Records, by Completed 24a. Wes en eutopsy performed? 24b. Were autopsy findings aveitable prior to completion of cause of deeth? 1 Yes 2 No certificata 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
24 hours after death.
Furnets Birector: After this certification by the funeral director.

Hely filled in by the funeral director. Be 25. Wes cese referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes av No 10 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyelotan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) end menner stated. Within 2 Within 2 To the 29b. Signeture end titte of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Resident 28495 March 6,1998 wazer tuo PHYSICIAN 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 22 S. GLEENE ST. BALTIMORE, MARYLAND J.NAZARIAN M.D. 32. Hegistrer's Signature Pandall 31. Date filed (Month, Day, Year) MAR 1 0 State Registrar

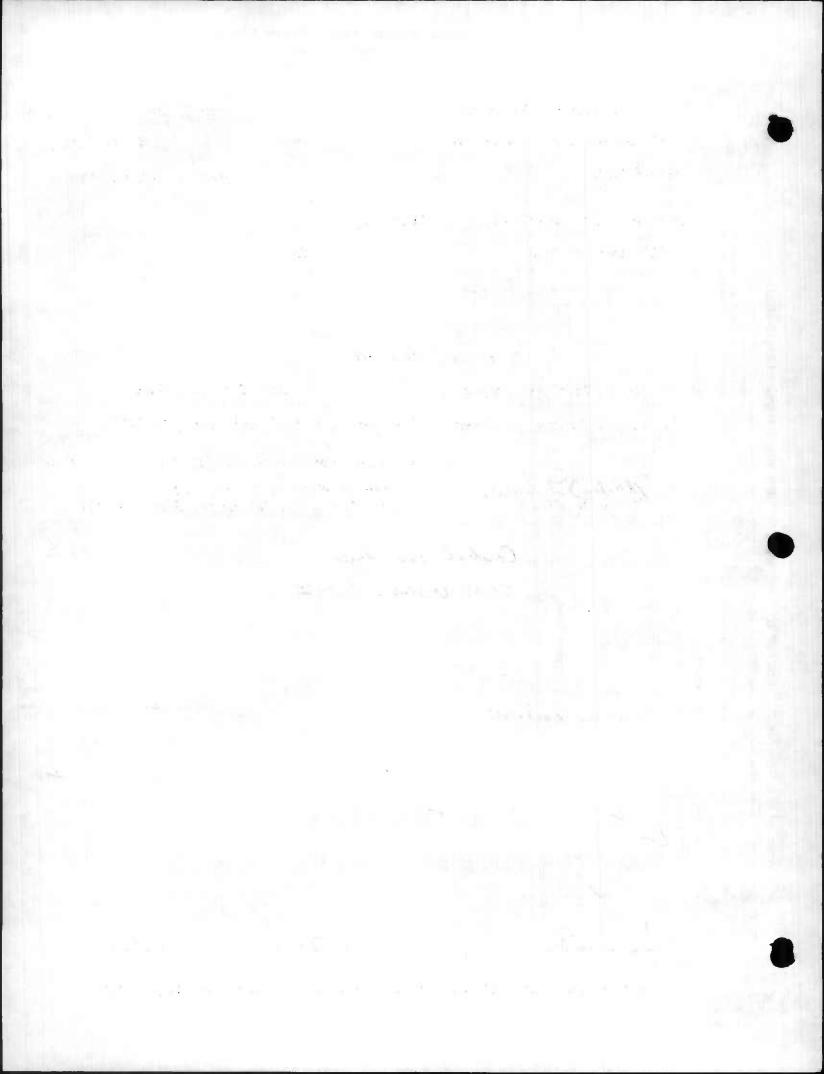


State of Maryland / Department of Health and Mental Hygiene 2 71,50

				Certifica	te of E	eath		Reg. No.		U
Maria Labora	1. Decedent's Name (First, Middle, I	ast)					2. Date of Dea	ath Day	3. Time	of Death
Physician /Medical	MARGARET D	AIGER McGRA	<u>AW</u>				March	7. 1998	4	20 AM
Examiner	4a Facility Nama (If not institution, g				41	. City, Town, or	Location of Death	4c. County	of Death	20 111
	St. Joseph's M				1	Towson			nore Coun	
neral		. Sex 7. Ag 1 M 25√7 F	e (In yrs. last birth	day) If Und Month	ar 1 Year s Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Da	h y, Year)	Birthplace (State Country)	or Foreign
or	219-18-4242 Usuai Residence of Decedent	A	76				March	5, 1922	Maryland	
	10a. State 10b. County		10c. City, Town	or Location	_				10d. Inside	City Limits
5	Maryland Baltimon	ce County	Wi1+	ondale					1 🗆 Y	s 2 No
20	10e. Street and Number	Le Courty	WATTC	7	ip Code			10g. Citizen of W	hat Country?	
Funeral Director	633 Coventry R	oad			21	286			USA	
era	11. Marital Status	12 Was Decedant	Evar in U,S.	13. Was Dec	edent of His	panic Origin? (S	pecify Yas or No o Ricen, etc.)	14. Race	- American Indian,	
F.	1 Nevar Married 2 Married	Armed Forcas?	No				o Ricen, etc.)	Blac	k, Whita, etc.	
by	3 XWidowed 4 ☐ Divorced	If Yas, Give Year or Dates:		1 🗆 Yes	2 X No	Specify:		Specify.	White	
Completed	15. Decedent's	Education	16a. D	ecedent's Us	uai Occupa	tion	dulas	16b. Kind of Bu	siness/Industry	
ple	(Specify only highest g Elamentary/Secondary (0-12)	Coilega (1-4or s	5+)	ife. DO NOT	use ratired)	uring most of wo	KIII			
TO.		2 yrs		omemake	er			Own Re	esidence	
Be	17. Father's Name (First, Middle, La	st)				18. Mother's Na	ne (First, Middle,	Maiden Sumam	9)	
2	Joseph Perci	val Daige	2			Mary	Cecilia	Smith	1	
	19a. Informant's Name/Relationship	(Type, Print)	19b. N	Mailing Addre	ss (Street a	nd Number or Ri	ural Route Numbe	er, City or Town,	State, Zip Code)	
	Patricia M. Linz	ey (Daughte				Road,	Baltimor			
	20a. Mathod of Disposition 1 XBurial 2 Cremation 3	□Removal from State	20b. Place of D cemetery,	Disposition (A , cramatory o	ama of r other place)	Date	20c. Location -	City or Town, Stata	
2	4 Donation 5 Other (Spec		Dulaney	Valle	ev Men	. Grdns	3/10/98	Timoni	ım, Maryl	and
any Injury	21. Signature of Funeral Service Llo	ensee/		22. Nama	and Address	of Facility				
4 8	Martin	Jawm		Mitch	ell-Wi	ledefeld	Home, 1	nc.		
	Martin D. La 23a. Part 1. Enter the disease, or co shock, or heart failure. List on	WSOT mplications that caused	tha daath. Do no	6500 T	ork R	oad, Ba	ltimore, or raspiratory a	Marylar rest,	nd 21212 Approxim	nate
sician	shock, or heart failure. List on	ly one ceuse on each in	ne.						Onset an	d Death
edical	immediate Cause (Final	0	0/	/					114	0
niner	disease or condition rasulting in daath)	a. Cerch	Dua to (or as a co	menta	ge-				1 11	_
9		0 00 00			NCCA.	~			t t	
Examiner	Conventially list conditions	b. Covis	Due to (or as a co		11327	2			1	_
Ex	Saquentially list conditions, if any, leading to immediata ceuse. Enter Underlying Causa (Disaasa or injury		040 10 (01 45 4 00	niacquunioo o	.,.					
edical	that initiated events	c	Due to (or as a co	nsequence o	Ŋ:					
Pe	resulting in death) Last		200 10 101 20 20 00	113044411000	,.					
3		d								
d for	Part II. Other aignificant conditions	contributing to death b	ut not resulting in I	lhe underlying	cours alve	n in Part I	1			e of death?
etached for use Physician/	. a.t ii. Other algrimoatit conditions		at not read till gill I	undanying	, Joursa GIVE		23h Did	tobacco use cor	tribute to the caus	
	Λ					mmran.i.			atributa to the caus	
	DIMENES C	BULLIUS				THE COLL.	23b. Did		tributa to the caus	
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b b	Disses -	eceiTVS				iiii Faiti.	1 🗆 24a. Was	Yes 2 No	3 Probably 4 24b. Were autops available pricompletion of	Unknown
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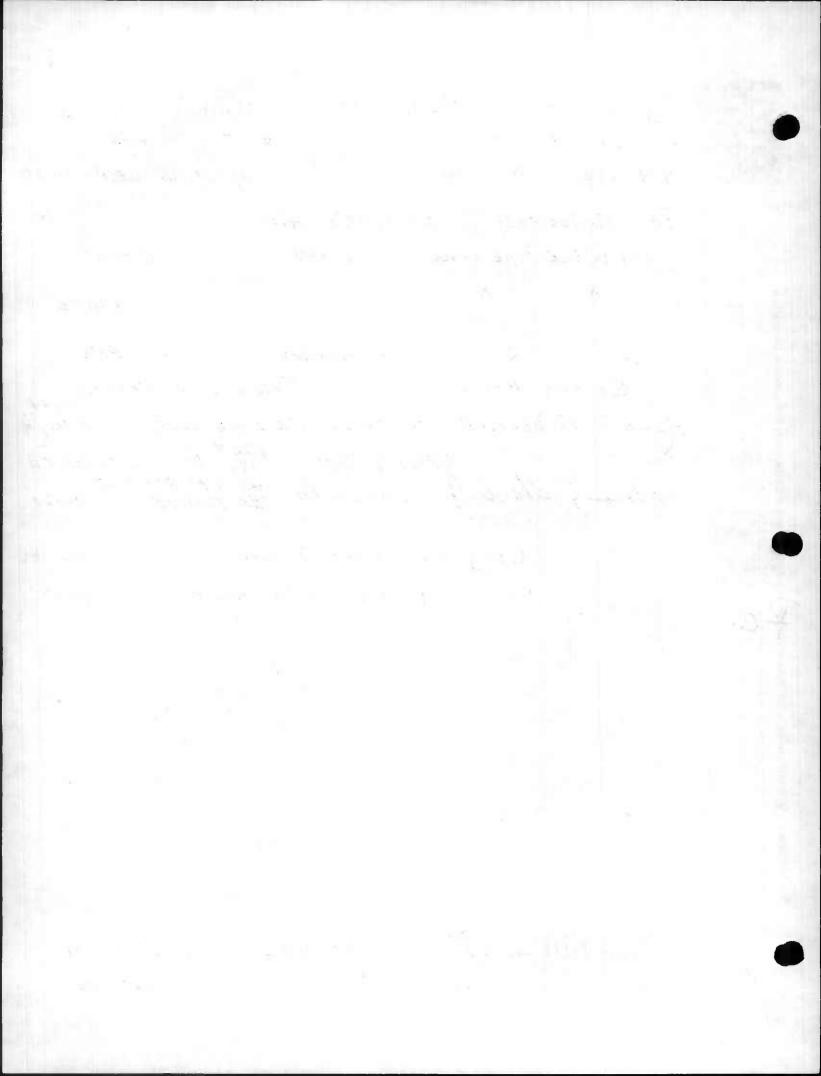
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DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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a .		10a. Stete 10b. County	10c.	City, Town or Location			•		10	Od. Inside City Limits
octor	Ď.	PA. MONTGO	MERY	LAFAY	ETTE	Hill				1 ☐ Yes 2
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TO BE

ALEXANDER S
31. DATE FILED (Month, Day, 1687)
MAR 1 01998

D ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

30 REGISTRAR'S SIGNATURE
Julia Daydon-Rondall

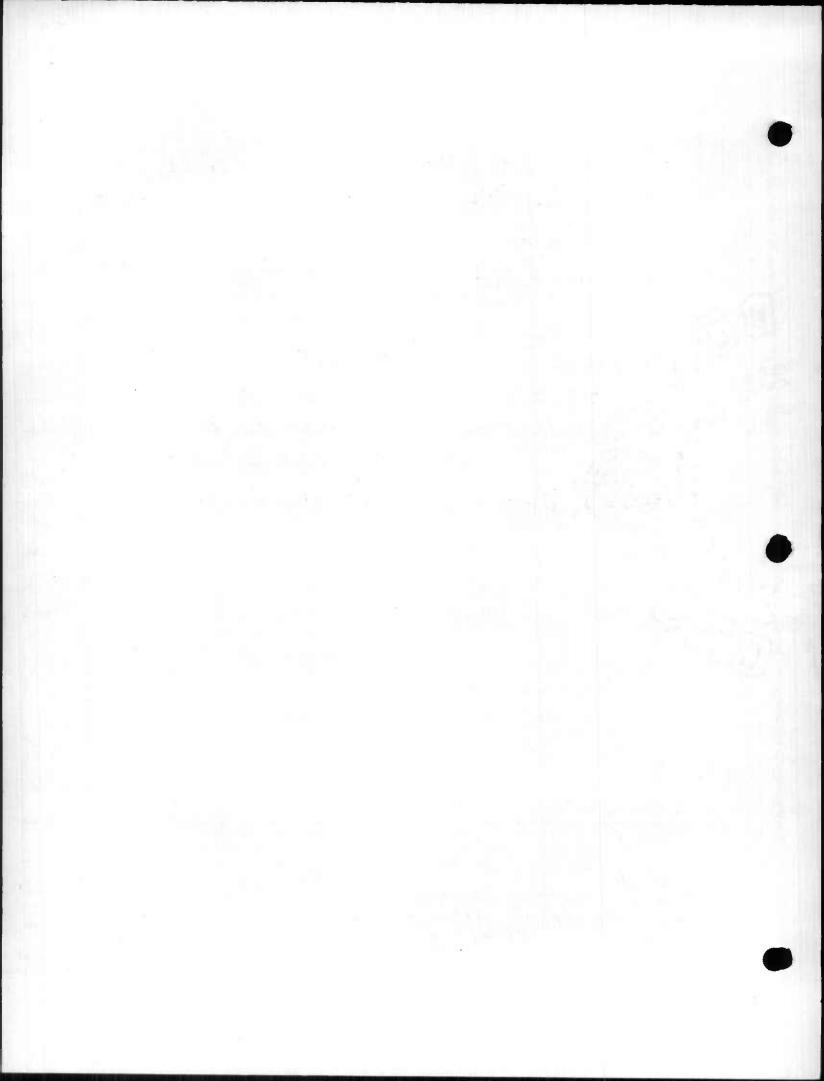
SY MD

4 10 1	I. DECEDENT'S NAME (First, Middle, Last)		CERTIFICAT	E OF DEATH	REG. NO.	_	3. TIME OF DEA
		CHALSKI			MARCH 5	199	EAR
1	A. SOCIAL SECURITY NUMBER		(in yrs. leaf birthday) IF UNDE	R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (States or F
	Z13 30 1640	1 M 2 F	./4 YRS.	Y, TOWN OR LOCATION OF D	5.16.9	9 1	LKRAIN
CTOR	Church H	OSPITAL		BALTIMOR		9c. COUNTY	V/4
	MARYLAND 106. COUNTY	J/A	10c. CITY, TOWN	ALTIMOR	٤		10d, INSIDE CIT LIMITS? 1 YES 2
VERA	2931 EASTE	RN AUE		101. ZIP CODE 2/2	24	21	N OF WHAT COUNTRY?
BY	11. MARITAL STATUS t Never Married 2 Married 3 Never Married 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 Y NO	I WAS DECENDENT OF HISPA If yes, specify Cubers, Maxic t YES 2 NO Speci	en, Puerto Ricen, atc.)	or No- 14.	Specify: WHIT
邑	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S USUAL ((Give kind of work done	during most of working	16b. KIND OF BUS	SINESS/INDUS	TRY
PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	HOME (MAKER	OWN	1 ho.	ME
COMPL	17. FATHER'S NAME First, Middle, Last)	1	11011101	18. MOTHER'S NA	AME (First, Middle, Maiden		
ш	KOMAN	LATICH	OVA	MAK	CIA DK	OZD	
0 P	19a. INFORMANT'S NAME (Type/Print)	11:0000	19b. MAILING ADDRES	SS (Street and Number or Rural	Ploute Number, City or Tow	n, State, Zip Co	ode) 7/77
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1	1 Buriel 2 Cremetion 3 Rem 4 Donetion 5 Other (Specify)		o, PLACE AND DATE OF DISPO	571K Com	3.9 RA	1th C	my or lown, state
1	21. SIGNATURE OF FUNERAL SERVICE LIC	сеньји	22	. NAME AND ADDRESS OF F	ACILITY	40 0	7122
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/	AMILLER	2041101	she d	An TOPAUSA	E: F-H	1301	Nundark
4	23. PART I. Enter the disease, or			ACZOKO WS/	F. H.	12014	Jundark t, Approxim
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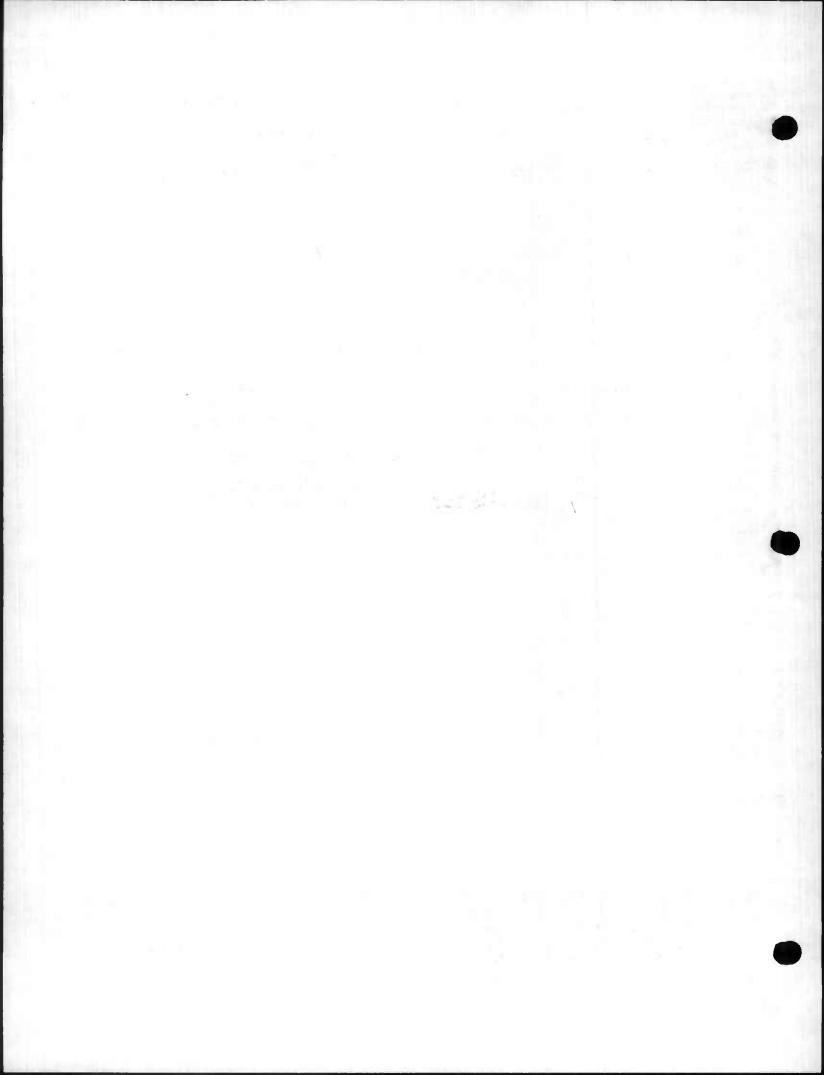
98 NO. BROADWAY STE 307

DHMH-18 Rev 1/89

BALTIMORE MD 21231



		Decedant's Name (First, Middla, La	nst)		(Certificate o	of L	Death	2. Date of De	Reg. No.		3 Ti-	ne of Daath
Physician /Medical		HELEI		MA	TUSZAK				MARCH		1998		35 AM
Examiner	_	4e. Facility Nama (If not institution, gh MERCY MEDICAL						b. City, Town, or Lo BALTIMOF		h 4c. C	ounty of Deat	h	
uneral irector	- 1	219-09-0833	Sex 1 □ M 2 □ F		(In yrs. last birth	day) if Undar 1 Ya Months Da		If Undar 24 Hrs. Hours Min.	8. Data of Bill	th ay, Year)	9. Birt	hplece (Si	ata or Foraigi ND
show	-	Usual Residence of Decedent 10a. State 10b. County		1	10c. City, Town	or Location						10d. Insi	da City Limits
uned uned ctor	CTO	MARYLAND	N/A		BAL	TIMORE						1 🛚	Yes 2□No
or 28a-1 s be notified	DIL.	10e. Street and Number				10f. Zip Cod		<i>i b</i>		-	an of What Co	ountry?	
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2 6 0	ă	FRANK KOZLOWSK	,					ESTELL		, ivieldan o	umania)		
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8		20a. Mathod of Disposition Purial 2 □ Cramation 3 □ Donation 5 □ Othar (Speci	(y)	State	cematary	Disposition (Name or cramatory or other TANISLAU	JS	CEM 3-	- 1 2	BALT	otion - City or		ta
solo diam		21. Sign turn of Funere Service that 23a Part. Enter the disease, or coff shock, or heart failure. List only	100-20	wusad the	na death. Do no	1201 DL	IN	ss of Facility SKI FUNE DALK AVE g, such as cardiac o	F. BAL	TO.	MD. 2	1222 Approx Interva Onsat	
lical iner		Immediata Cause (Final disaasa or condition rasulting in deeth)	a		ASTIC	CANCER						20 D	AYS
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be deteched by Physic									10	Yas 2	No 3 P	robably	4 Unknow
2 should					Ш				24a. Was	an eutops ormed?	´	Wara auto eveileble p completion of death?	psy findings prior to n of cause
раде	5								1 🗆	Yas 200	No	1 🗆 Yas	25 No
director, pag		25. Was case rafarred to medical examiner?	Hospitai:	4			Otha	26. Placa of Daatt					
		1 Yas 2 No 27. Mannar of Death 1 Natural 5 Panding 2 Accident invastigatio	28a. Data (Mon			ma of 28c. I	Injury Work	4 Nursing Ho	ma 5□ Rasi 28d. Describe		-	cify)	
		3 Suicida 6 Could not b 4 Homicida datarmined	28a. Place	a of Injury ing, etc.	r - At homa, fam (Specify)	n, straat, factory, offi	ica		28f. Location (City or To		Number or Re	urel Route	Number,
stely fill		29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exar	ysician: To the niner: On tha be and man	asis of e	xamination and/	deeth occurred et the or Invastigation, in m	e tim	na, data and placa, pinlon, daath occurr	and due to the ed at tha tima,	ceuse(s) e data and p	nd menner es laca, and due	statad.	usa(s)
To the comple		29b. Signature and titla of certifiar	,	1		29c. Lic	ense	number		29d. Date	signed (Mont	h, Day, Ye	er)
	-	F. GANSI	and			D.	10	229		MARC	H 10,	199	8
		MS. RACHEL B	URDICK	38	S. GR	EENE STE	RE	ET U. O	F MD.	MEDI	CAL S	YSTE	M
State		31. Date filed (Month, Day, Yaar) MAR 1 019	32. R	Registrar's	Signatura Davidson	Dang. 00.							1



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Deeth 3. Time of Deeth 00 1998 05 46. County of Deeth 4b. City, Town, or Location of Death, 2600 Liberty He. 4a. Facility Name (If pot Institution, give street and number) Baltimove MD 3

If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Feb. 27, Medica CENTER 7. Age (in yrs. lest birthdey) 5. Sociel Security Number 6. Sex Birthplace (State or Foreign Country) 10 M 2 F Yrs. T913 216-12-0752 Pennsylvania Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore YOYes 2 No Maryland N/A 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 4017 Liberty Heights Avenue 21207 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 AWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Domestic Private Family 18. Mother's Neme (First, Middle, Melden Sumeme) 17. Fether's Neme (First, Middle, Last) Irene Griannage William A. Dayd 19a. fnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Virginia Williams 1207 Oakhurst Place, Baltimore, MD 21216 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Cremetion 3 Removel from State National Memorial 3/10 Md. 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 22. Name and Address of Facility
Marshall W Jones, Jr Funeral Home P.A.
4101 Edmondson Ave, Baltimore, MD 212 21. Signature of Funerel Service Ligana MD 21229 23e. Part1. Enter the disease, or complicetions there is sed the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) da Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of):

Bnd Division of Vital Records, P.O. Box 68760, sate hes been signed by the atter-page 2 should be detached for certificate

Physician /Medical

Examiner

/Medical E

Examiner

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Heelth and Mental Hygiens. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examines must be notified at

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I

State Registrar

ontributing to death but not re-	sulting in the underlyin	g cause given in Pert I.	23b. Did tobacco use co	ontribute to the cause of death? 3 Probably 4 Unknow	
			24a. Wea an autopsy performed?	24b. Were autopsy findinga eveilable prior to completion of cause of death? 1 Yes 2 No	
Hospitel: 1 Inpatient 2	☐ ER/Outpatient 3☐	Home 5 ☐ Residence 8 ☐ Ott	ner (Specify)		
28e. Dete of Injury (Month, Day Year) 28b. Time of Injury et Work? 28d. Describe how Injury occurred					
28e. Place of Injury - At h building, etc. (Speci	nome, ferm, street, fect ify)	ory, office	28f. Location (Street and Num. City or Town, Stete)	ber or Rural Route Number,	
	Hospitel: Impatient 20 28e. Dete of Injury (Month, Day Year) 28e. Place of Injury - At h	Hospitel: 2 ER/Outpatient 3 28e. Dete of fnjury (Month, Day Year) 28b. Time of Injury M	28. Place of D. Hospitel: 2 ER/Outpatient 3 DOA Other: 4 Nursing 28e. Dete of fnjury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No 28e. Place of D. 28e. Place	1 Yes 25 No 24a. Wea an autopsy performed? 1 Yes 25 No 24a. Wea an autopsy performed? 1 Yes 25 No 28b. Place of Deeth (Check only one) 1 Yes 25 No 28b. Deeth (Check only one) 28c. Injury et 28c. Injury et 28d. Describe how Injury occur work? 1 Yes 2 No 28b. Place of Injury - At home, ferm, street, fectory, office 28f. Location (Street and Num.) 28c. Injury et 28f. Location (Street and Num.) 28c. Injury et 28f. Location (Street and Num.) 28f. Location (

29c. License number

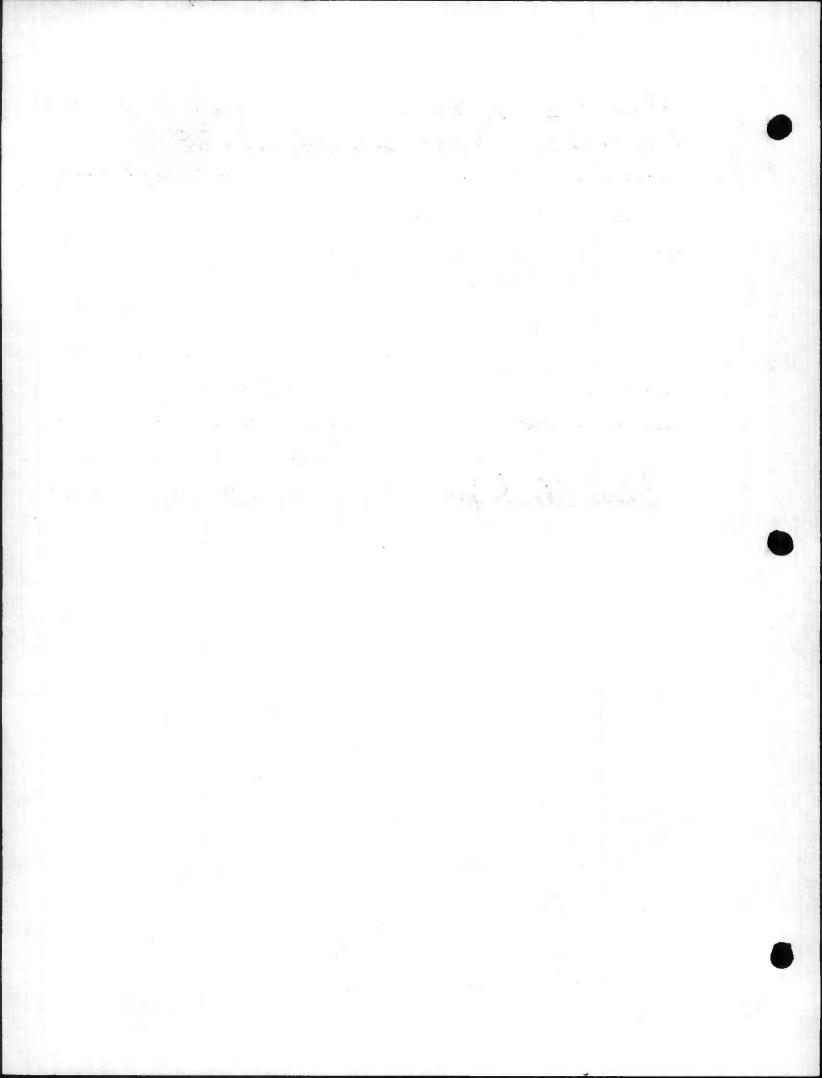
29d. Date signed (Month, Day, Year)

30. Neme and address of person who comp of death (Item 23a) (Type, Print)

31. Date filed (Month, Dey, Year) MAR 1 0 1998

29b. Signeture end title of certifler

33 Registrar's Signeture Durds



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 10e per F.H.G-757 3/10/98 reb Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Mary **Physician** Wayne Gerard Meadows /Medical **Examiner**

Director with the Meryla VANNE and Mental

item 27 is marked other than "naturel", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at marked other than Department of Health Important: If Item 27 eny injury or o

Funeral

Director

Funeral

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Certification: To

Medical

Physician /Medical Examiner

physician the SB 950 funeral director, this

after death Director: 24 hours a Funeral C To the F within 2

Division of Vital Records, P.O. Box 68760

4b. City, Town, or Location of Deeth 4e Facility Name (If not Institution, give street and number) 4c. County of Deeth North Arundel Hospital Glen Burnie Anne Arundel If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 6. Sex 1 → M 2 → F If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 54 yrs Birthplece (State or Foreign Country) Months Deys Yrs. 216-44-5052 Oct. 3, 1943 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Anne Arundel Severn 10e. Street end Number QUARTERFIELD RD 8092 Quaterfield Road 10f. Zip Code 10g. Citizen of Whet Country? 21144 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yas, Give Yeer or Dates: 1 Never Merried 2 Merried 1 ☐ Yas 2 ☐ No 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8th Truck Driver Dickerson and Hefner 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marvin Meadows Loretta Murray 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19e. Informent's Neme/Ralationship (Type, Print) Patricia Meadows (Wife) P 0 Box 130 Severn, Maryland 21144

20b. Place of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Meadowridge Memorial Park 3/7/98 Elkridge, Maryland 22. Name end Address of Fecility
McCully-Polyniak Funeral Home 21. Signeture of Fuperal Service Licensee Kevin E. 237 E. Patapsco Avenue Balto., 23e. Pert Enter the disassa, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or haart failura. List only one causa on each lina. Approximete Intervel Between Onset and Deeth Immediate Cause (Final disease or condition rasulting in daath) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated evants resulting in deeth) Lest Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

			÷			24e. Wes en eutopsy performed?	24b. Were autopsy finding eveileble prior to completion of cause of death?			
25. Wes casa rafarrad to medical				20	6. Plece of Dec	eth (Check only ona)				
examiner? 1 Yes 2 No	Hospitel: Inpatient 2	ER/Outpetient	3 DOA	Other:	4 Nursing H	loma 5 ☐ Rasidance 6 ☐ Ott	har (Specify)			
27. Menny of Deeth 1 Naturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes	2 🗆 No	28d. Describe how Injury occurred				
3 Sulcide 6 Could not be determined	28e. Place of Injury - At home, farm, street, lectory, office building, etc. (Specify)					28I. Location (Street and Num. City or Town, State)	ber or Rural Route Number,			

29b. Signeture end titla of cartifier

(Check only one)

mo

w Davids

29c. License number

2 Madical Examinar: On the basis of exemination end/or investigetion, in my opinion, daeth occurred at the time, date end placa, and due to the cause(s) end menner stated.

29d. Dete signed (Month, Dey, Year)

3. Time of Deeth

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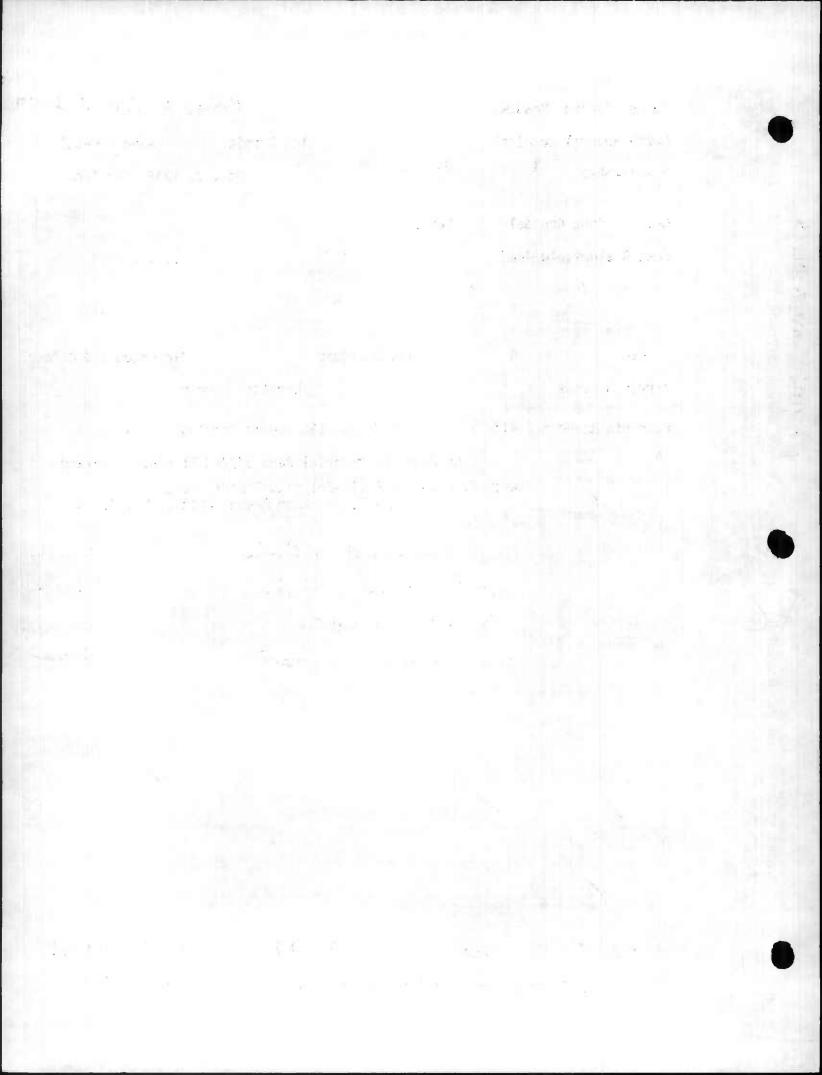
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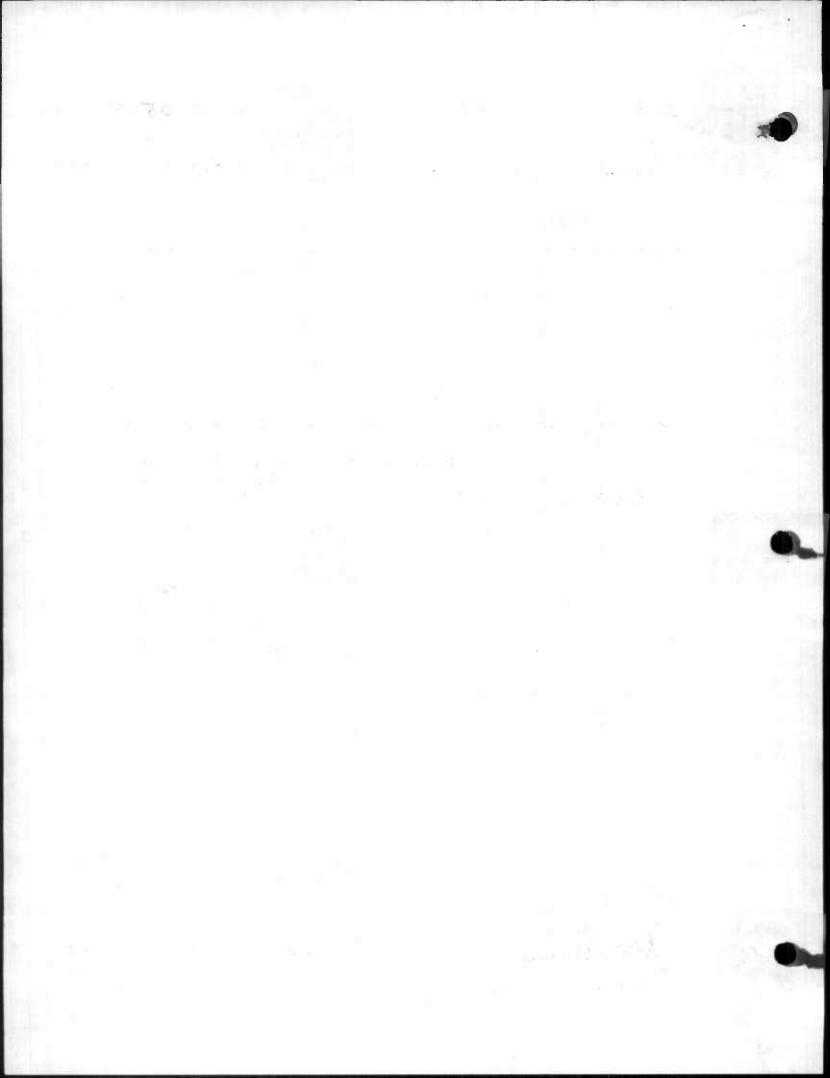
30. Name and eddress of parson who complated causa of death (Itam 23a) (Type, Print)

PreTurn - 301 Houston Dre 31. Data find (Month, Day, Year) 32 Registrer's Signature

State Registrar

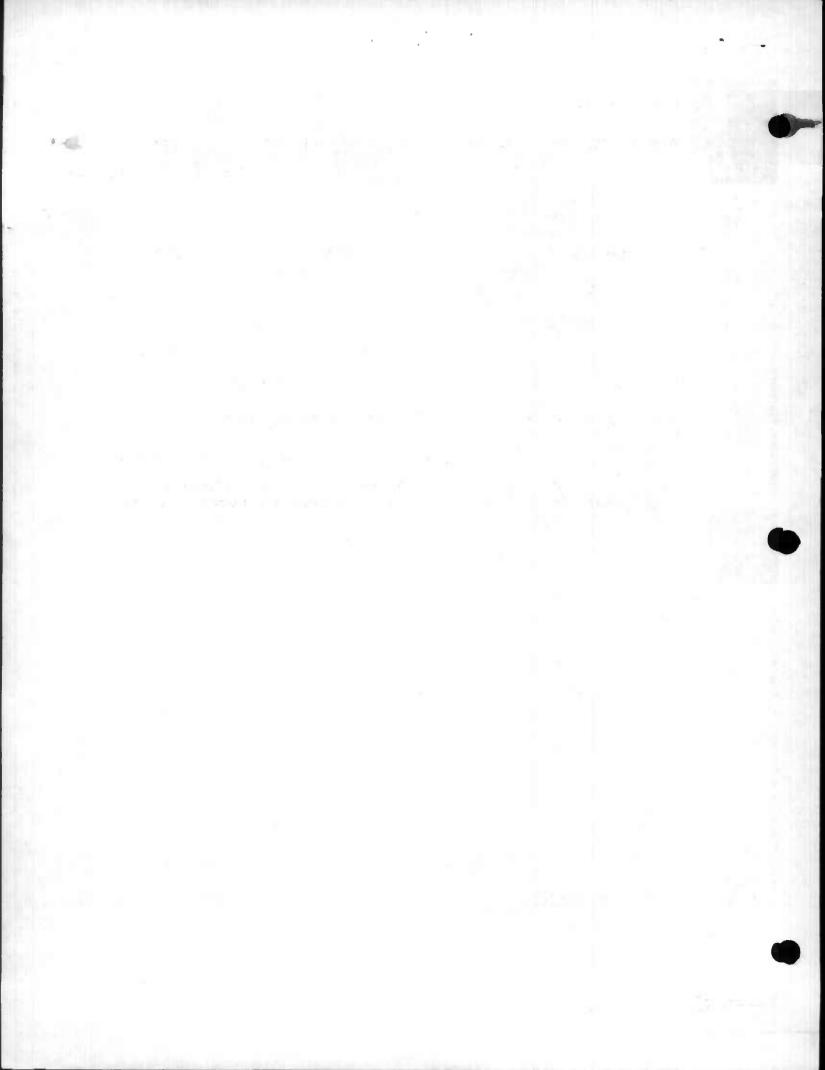


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niner	4	a. Fecility Neme (If ST. AGNI	not institution, gh ES NURSI		m <i>ber)</i>				4b. City, Town, or L ELLICOTT		h 4c. Count HOWA	y of Deeth RD		
al or		5. Sociel Security No. 014–36–81	123	Sex 1□M 270 F	7. Age (in yrs	. lest birthdey) 37 Yrs.	If Under Months	1 Year Deys		8. Dete of Bi	nth 9990	9. Birthpi Count	ece (Stete or SWEDE	Foreign IN
	-	Jsuei Residence of 10a. Stete	10b. County		10c. C	ity, Town or Lo	ocation					10	Od. Inside Cit	y Limits
ctor		MD	HOWARD		(COLUMBI	A						1 🗆 Yes	XXNo
al Director		10e. Street end Num 10222 Ma		AVENUE			10f. Zip	Code 104	4		10g. Citizen of U.S.		try?	
by Funeral		1. Meritel Stetus 1 ☐ Never Marrie 3 ☐ Widowed		12. Wes Deci Armed Fo 1 Tes, Gir Yeer or D	2 No		Wes Deced If Yes, spec 1 ☐ Yes 2		Hispanic Origin? (Spen, Mexicen, Puerto Specify:	pecify Yes or No Ricen, etc.)		ce - America ock, White, e fy: WHTT	etc.	
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To	-	AUGUST		T	LARS	1		10.	ELIN LINDGREN et end Number or Rurel Route Number, City or Town, Stete, Zip Code)					
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ny injury or other	2	20e. Method of Disposition 1 ☐ Buriel 2 ☐		Removel from	20b. Stete	Plece of Dispo cem <i>etery, cre</i> r	sition (Nem	ne of ther ple		Dete	20c. Location			
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should be detached for use as the burial-transit and lead to the state of the state		disease or condition resulting in deeth) Sequentielly list con if eny, leeding to impeuse. Enter Under Cause (Disease or linet intileted events resulting in deeth) L	aditions, mediete tying njury	e. 9 AST/	Due to (or es e consequence es	quence of):		Huty				Ay	
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To Be	2	25. Wes case referre exeminer? 1 Yes 2 1		Hospitai:	Inpatient 2	ER/Outpetler	nt 3 DO	Ot	28. Place of Dee		one) Idence 6 □Ot	10-14	a)	
ation: T	2	7. Menner of Deeth 1 Preturel 2 Accident		28a. Dete		28b. Time of Injury		8c. Inju			how injury occu)	
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edicai	2	29e. Certifier (Check only one)	1 Certifying Ph 2 Medicai Exar	niner: On the bi	best of my kno aels of examino ner steted.	owiedge, deeth etion end/or inv	occurred evestigetion,	in my	ime, date end piece, opinion, deeth occur	and due to the red et the time,	ceuse(s) and m dete end place	anner as sto and due to	eted. the ceuse(s)	
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

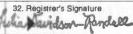
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 1998 BETTY ONION 6:15 AM ALETHIA /Medical 4b. City, Town, or Location of Deeth TOWSON 4a Fecility Name (If not institution, give street and number)
Saint Joseph Medical Center 4c. County of Deeth Baltimore Examiner 8. Date of Birth July 15 1928 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□M 2☑F Months Deys Hours Min. Towson, Maryland 217-24-6568 69 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County Baltimore 10c. City, Town or Location Baltimore 10d. inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at MD. 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ŏ 8501 Oakleigh Rd. 21234 USA permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a eny injury or other traumatic event, the Medical Examiner pages. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian. 11. Meritai Status Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Albert H. Jones Lillian Morris 2 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Mr. James R. Onion, Jr./Husband 8501 Oakleigh Rd. Baltimore, Md. 21234 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State Dulaney Valley Mem. Gar. 3-12-98 Timonium, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, MD. 21204 21 Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** RESPIRATORY FAILURE Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) PNEUMONIA Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last bunial-tran Due to (or as a consequence of): physician that the death certificete be Physician/Medical the Due to (or as a consequence of) use as or signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yss 2 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy peeu has pege 2 1 Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certific funeral director, Be 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

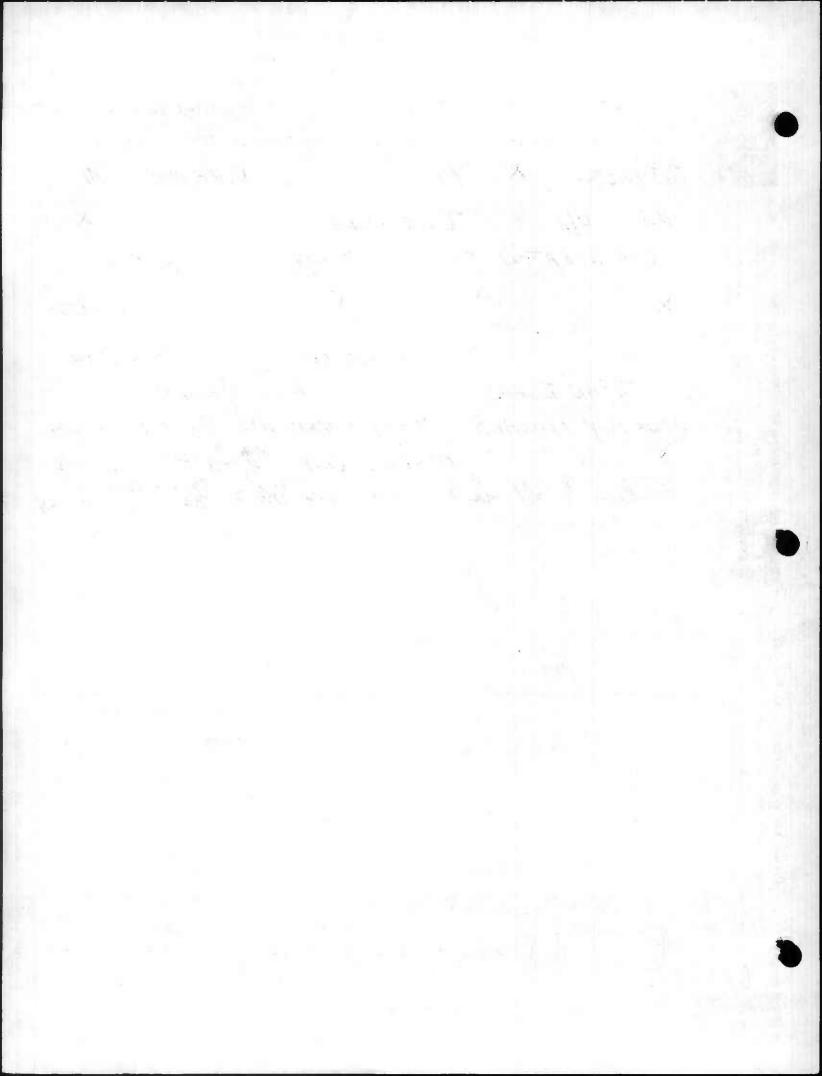
2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier To the To the 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number D 30263 3-9-98 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) FRANCIS KHOO, M.D., 7620 YORK ROAD, FRANCIS KHOO, M. D. , TOWSON, MARYLAND 21204

State Registrar 31. Date filed (Month, Dey, Year)



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/Medic		EDNA O	BERLA	NDE	K		FEBRUAL	17°26-	1998 1	On LW
Examin	er	4e. Fecility Neme (If not institution, give				4b. City, Town, or		4c. County	of Death	
		CANTON HAABO				0	ONE MD		N/A	
Funeral Director		5. Sociel Security Number 6. Se 2/3-10-6344 Usual Residence of Decedent	M 2 F 7. Age	In yrs. lest bi	rthday) If Under 1 Yea Months Days				9. Birthplace (S	State or Foreign
Maryland -f show		10e. State 10b. County		10c. City, Tov	n or Location				10d. Ins	side City Limits
Mar	to	MD. N/A		BAI	TIMORE				此	Yes 2□ No
with the	Director	10e. Street end Number			10f. Zip Code		100	g. Citizen ot V	Vhet Country?	
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ams 23	Funeral	11. Maritel Status	12. Was Decedent E Armed Forces?	ver In U,S.	13. Was Decedent of If Yes, specify Cu		Specify Yes or No-		a - American Indi	lan,
natural', or ita	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 DN It Yes, Give Year or Dates:	0	1 □ Yes 2 No	4	to moun, oto.,	Specify		TE
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certificate irector, pag			77(01				1 ☐ Yes		1 🗆 Yes	2 No
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ral d	٠ <u>۲</u>	1 ☐ Yes 2 No ☐	1 L Inpatien	2 ER/Ou	tipetient 3□ DOA ☐	4 Nursing F	flome 5 ☐ Residence			
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dean ctor: y the	Ca	3 ☐ Sulcide 6 ☐ Could not be	28e Place of Injur	u - At home, te			28f. Location (Stre	at and Numb	or or Purel Poute	Alumbar
Dire	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	rm, street, factory, offica	1	City or Town,	Stete)	or Hurar House	radificar,
	edical C	Check only 2 Medical Examin	ier: On the basis of e	xemination en	, death occurred et the t d/or investigetion, in my	time, date end place opinion, deeth occu	i, end due to the ceus	se(s) end mai	nner as stated.	use(s)
thin mple	-	one) 29b. Signature end title of certifier	end menner stete	ea.		nse number				
F 8		Lob. Ognature end title of caltiller	r	0					(Month, Day, Ye	
		Joseph D. No	noran	gels	M.D. D					
		30. Neme and address of person who co	mpleted cause of dee	oth (Item 23e)	(Type, Print)	201 01	RALLI DI	105	RAIT	IMORE
W		JOSEPH D. N				201 11.	17746 16	.,	07,11	
State	•	31. Date tiled (Month, Day, Year) MAR 1 0 1998	- Hegistra	s-Signature	nda 00.					
Registra	1	111711 T 0 1330	17 minus	I MODY NO	Independent					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Items: 10bcef Per Informat Film G-757 3-26-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day 1998 **Physician** MARCH 4, PIKE 12:25pm /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGE ff Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₽M 2□F Days 084-10-6936 Yrs. 86 Director MAY 8, 1911 NEW YORK Usuel Residence of Decedent with the Maryland 10a. State 10b. County MONTGOMERY 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Mexical Examiner must be notified at SILVER SPRING Yea 2□No Director COLUMBIA MARYLAND HOWARD 10e. Street end Number 2501 MUSGROVE RD. 10f. Zip Code 10g. Citizen of What Country? 20904 6336 CEDAR LANE 21044 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 DXYes 2 □ No If Yes, Give Year or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pagas 1 and 2 should be filed within 72 hours effar inent of Haelth and Mental Hygiene. Int: If Itam 27 Is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify by 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Elementary/Secondary (0-12) College (1-4or 5+) 4+ ATTORNEY INSURANCE COMPANY 17. Father's Name (First, Middle, Last) 18. Mother'a Neme (First, Middle, Maiden Surneme) Be SOLOMON PIKE FANNIE LTFSCHTTZ 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MRS. SUSAN BLACKMAN (DAUGHTER) 6371 SHADOWSHAPE PLACE COLUMBIA, MD 21044 other 1 20b. Place of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, State or 1 Burial 2 Cremetion 3 Removal from Stete Important: h any injury o COLUMBIA MEMORIAL PARK 3-5-1998 COLUMBIA, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Sol Eevinson & Bros., Inc. 21. Signature of Funeral Service Licensee seurson 8900 Reisterstown Road Pikesville, MD 21208 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) Examiner Examiner bile duct obstruction cartificata be executed attanding physicien end for use as the bunal-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 0 P.O. Box 68760 p515 Physician/Medical Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dfd tobacco use contribute to the cause of death? signed by 1 Yas 2 No 3 Probably 4 Unknown ementia Records, þ 24b. Were autopsy findings available prior to completion of cause of death? History of thyroid cancer 24a. Wes en eutopsy performed? Completed peed cartificata has 1 ☐ Yes 2 No Division of Vital 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: Aftar Attending 1 Natural 2 Accident 5 Pending Investigation daath. 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 28e. Plece of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral DI Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. edical 29a, Certifier complataly (Check only one)

0 State

1420 31. Date filed (Month, Day, Year) Registrar

29b. Signerare and title of certifier

PK. #102 Dr. Su Hogister's Signature Handage

29c. License number

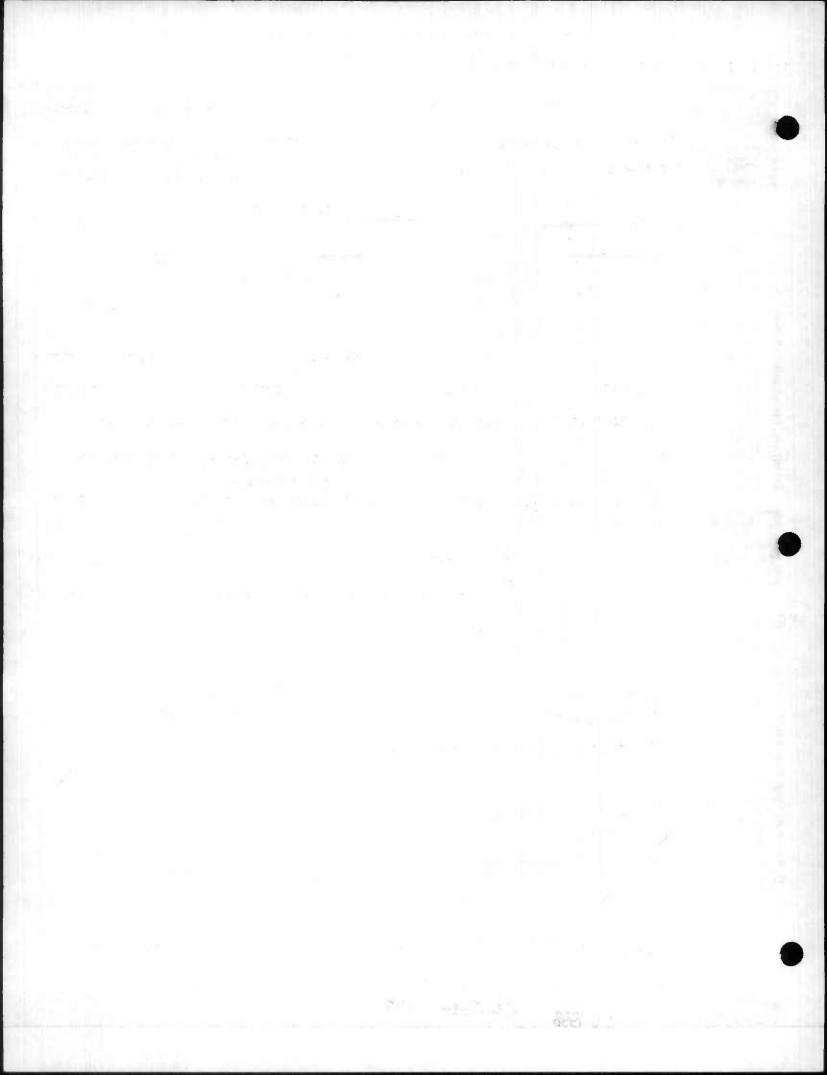
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Laurel MD 20707

29d. Date signed (Month, Day, Year)

1 0 1998

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

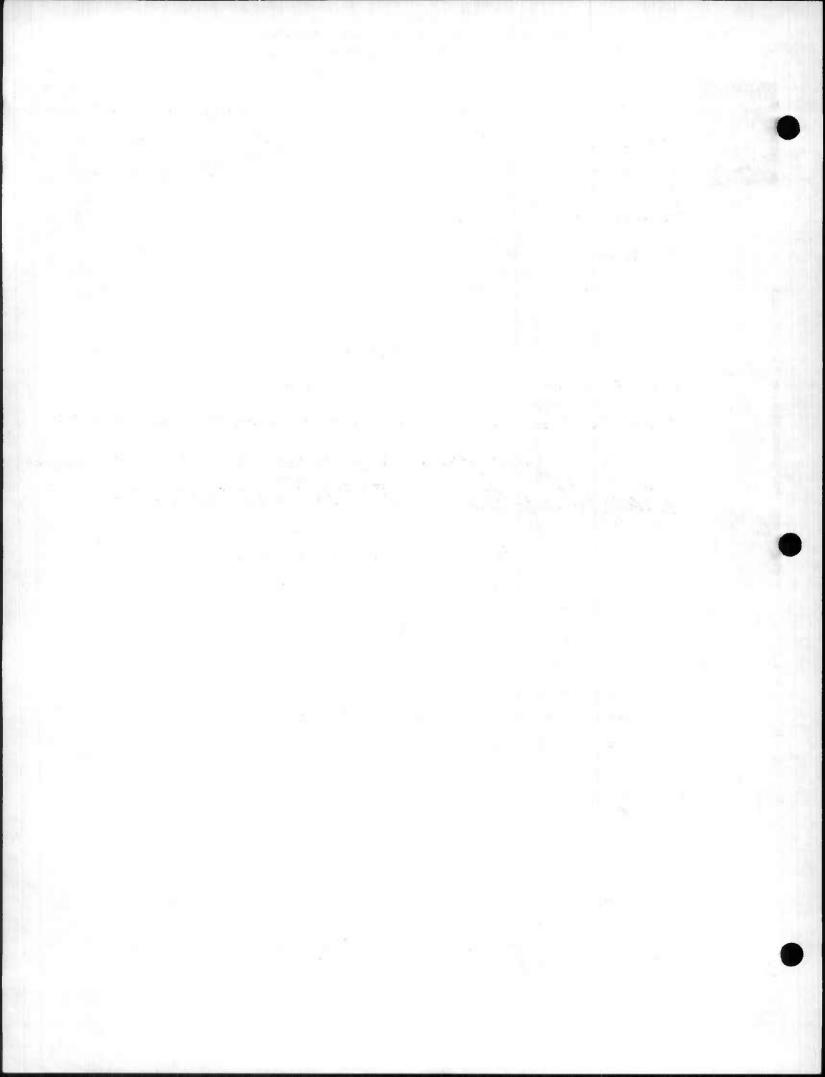


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/Media			utell					March	5 19	98	11:30 pm
Examir	er	4a. Facility Neme (If not institution	1	per)			4b. City, Town, or				
		Sinai Hospi					Baltimor		J	I/A	
Funeral Director		5. Social Security Number 215–10–4660	6. Sex 1 → M 2 □ F	Age (In yrs. le 92	est birthday) Yrs.	Months Dey		8. Date of Birt (Month, Da DEC	7, 1905	9. Birthp Coun Mary	ece (Stete or Foreign (In) Yland
pu »		Usuei Residence of Decedent 10e. Stete 10b. County		10c City	, Town or Lo	nation					Od Inside Otto I Inside
illed within 72 hours after death with the Maryland Hygiens. Hydrethan "natural", or items 23s or 28s-f show ent, the Medical Examiner must be notified at	-		/-	Too. City						1	0d. inside City Limits
or 28a-f	octo	Maryland N	A		Balt	imore					1 Yes 2 No
0 8	급	10e. Street end Number				10f. Zip Code	•	V 1	10g. Citizen of V	Whet Coun	ntry?
238	ra	6117 Berkeley A	ve., Apt.	B-2			209		USA		
items inst.m	Funeral Director	11. Marital Stetus	12. Was Decede	ent Ever in U,S as?	3. 13.	Was Decedant o if Yes, specify Co	f Hispenic Origin? (Suben, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Rac Bled	e - Amaric k, White,	
n of hearn and Mental rhygiens. If item 27 is marked other than "natural", or items 23a or 28s-f show or other traumatic event, its Medical Exorting must be notified at	by	1 ☐ Never Married 2 ☒ Marr 3 ☐ Widowed 4 ☐ Divorced	ed 1 X Yes 2 If Yes, Give Year or Dete	□ No es:		1□Yes 2 N			Specify		ITE
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5.2	S	12			Insu	rance Sa	lesman		Mutual	Of On	naha
nerked other than netic event, the M	Be	17. Father's Name (First, Middla,	Last)					me (First, Middle,			_
arke atic	2	Albert			Palte.	11	Sally		AC	delma	n
E E		19a. informant's Name/Reletions	nip (Type, Print)				et and Number or Ri				
am 27 is me ther traum		Mrs. Shirley Pa	ltell (Wif	(e)	611	7 Berkel	ey Ave, A	pt. B-2	Balto.,	MD 2	21209
t of		20e. Method of Disposition		20b. Pie	eca of Dispo	osition (Neme of matory or other p	nlace)	Date	20c. Location -	City or To	wn, State
Department Important: If any injury o		1 ☐ Buriai 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (S)		A	rling	ton Chiz	uk Amuno	3-8-1998	Baltim	ore,	MD
Important: If i any injury or once.		21. Signature of Funeral Service	domisee								
ESS	21. Significant of Funeral Service Mountee 22. Neme and Address of Facility Sol Levinson & Bros., In 8900 Reisterstown Road Pikesvill								nc.	m 01000	
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aminer		diseese or condition resulting in death)	e. AS	\$		neumo	onia				
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detached	Physician/Medical	Pert ii. Other eignificant conditio	ne contributing to deat	out not resur	any in me u	andenying cause	Aisou ii Laif I				the cause of death?
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pa								101	as 2 ANO	10	Yas 2□No
s certificata director, pa	Be	25. Was case referred to medical axaminer?	Hospital					eth (Check only o	na)		
this c	2	1 Yes 2 No	Hospital: 12 hp		R/Outpatier	IL SEL DON		dome 5 ☐ Resid			y)
fler	OU:	27. Menner of Death 1 Netural 5 ☐ Pendin	9	Injury Dey Year)	28b. Tima o injury	V		28d. Describe I	now injury occur	red	
tha f	Certification:	2 Accident investig	ation of he				☐ Yes 2☐ No				
Director:	틭	4 Homicide	ned 200. Place of	injury - At hon, etc. (Specify)	ne, farm, sti	reet, factory, offic	88	28f. Location (S City or Tox	Street and Numb vn, State)	er or Rura	I Route Number,
le le		V									
To the Funeral Director: completaly filled in by tha	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical I	g Physician: To the be examiner: On the basi end menner	s of examination	rledge, deatl on end/or in	h occurred et the vestigetion, in m	time, dete end piece y opinion, death occu	a, end due to the urred et the time,	ceuse(s) and ma dete end plece,	anner as st and due to	tated. o the cause(s)
To the Funeral Director: A completaly filled in by tha fi	Σ	29b. Signeture and title of cartifian				29c. Lice	nsa number		29d. Date signe	d (Month,	Day, Year)
		May Main	MD			A 5 2 4	10 2321 MI	7-9921	March	5,19	92
,		30. Neme and eddress of person	who completed cause	of death (Item :	23a) (Tvpe			1 -2-1		7111	
		MOND MIREL	TID S	Mitte	Chit	1	21 Hmn	4			
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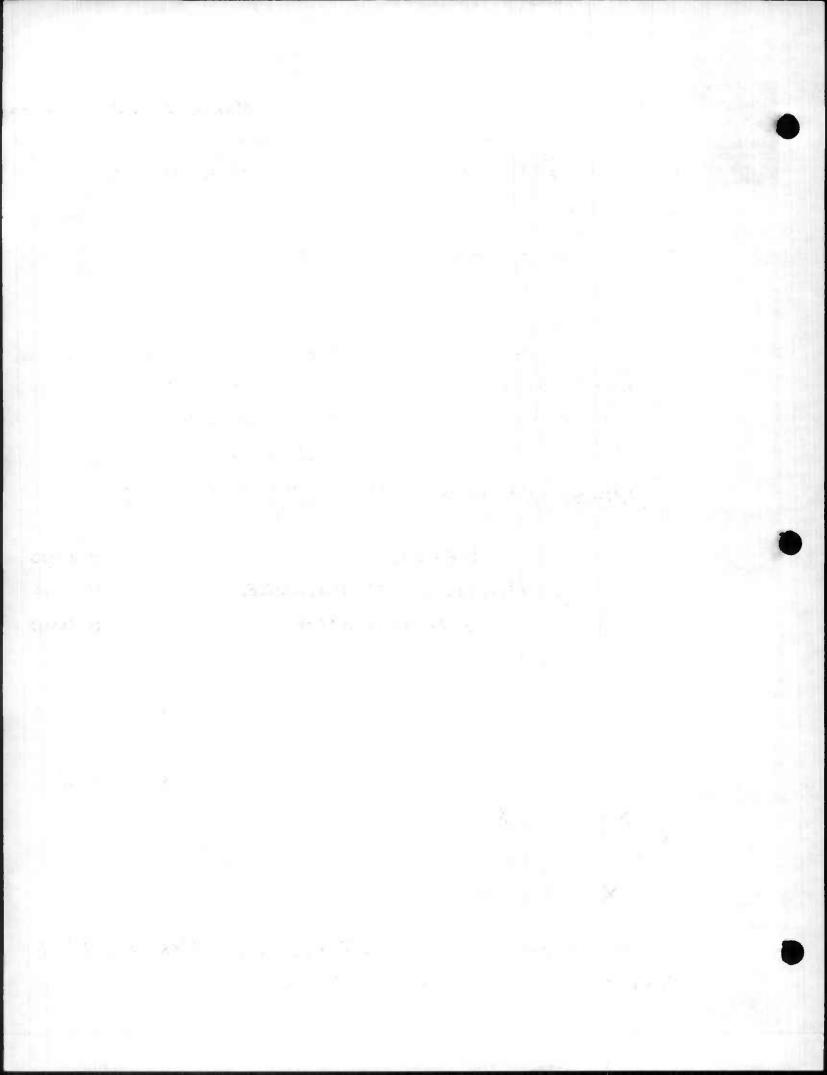
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					Certificate			Reg. No.	0/462
	Physici	ian	1. Decedent's Name (First, Middle, Last)	Piper			2. Date of Dec	Dev	Year 1998 4:42am
į.	/Media		4e. Fecility Name (If not institution, give street and r			4b. City, Town, o	March Location of Deeth		
	LAGIIIII	ici	Union Memorial	HOSP.		Bal	timore	N/	A
	Funeral Director		5. Social Security Number 6. Sex 2 2 0 - 2 0 - 7 4 7 1 1 M 2 T	7. Age (In yrs. last 7 4	t birthday) If Under 1 Yrs. Months		s. 8. Date of Birt		9. Birthpiece (State or Foreign
dand	Mo w		10e. State 10b. County	10c. City, T	Town or Location				10d. Inside City Limits
Man	D	tor	Maryland N/A	Balt	imore				Y⊑XYes 2□No
ith the	or 28	Dire	10e. Street and Number		10f. Zip C			10g. Citizen of W	het Country?
ath w	230	rai	3342 Chestnut Avenu		212			USA	
d 21215-0020 filed within 72 hours after death with the Maryland	"natural", or items 23a or 23a-f ahow soical Expenient must be notified at	by Funeral Director	11. Maritel Status 1 Never Married 2 Married 1 Yes, Uses De Arm	ecedent Ever in U,S. Forces? 5 2 Ø No Bive Dates:	13. Was Decede	nt of Hispenic Origin? (y Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)		- American Indian, k, White, etc. White
21215-0020 J within 72 hours af	1 natur	Completed		(1-4or 5+)	IBe. Decedent's Usual (Give kind of work life. DO NOT use Homema	done during most of w retired)	orking	16b. Kind of Bus	siness/Industry Home
d 2	Hygie ther ant, tr		17. Fether's Name (First, Middle, Last)		пошеша		ame (First, Middle,		
lan le pe	and Mental Hygiena. s marked other than sumatic event, tre M	To Be	Frank Crawford				C. Burk		
Maryland	and N is man		19e. Informent's Name/Relationship (Type, Pnint)		19b. Meiling Address (
- 2	Haalth am 27 ther tr			usband					,MD 21211
S	Department of Haalth Important: If Item 27 any injury or other ti once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify) □ n t 0 □	n State cem	a of Disposition (Name etery, crematory or oth id Ridge	er placa)	3 / 7		City or Town, State ille, Maryland
Baltimo	Departmen important: any injury once.		21. Signature of Funeral Service/Liogrise	tu	Burge 6	Address of Facility E-Henss F Falls Roa	uneral d, Balt	Home P.	.A. 21211 Maryland
	•		23a. Part I. Enter by document or complications that shock, or have fallure. List only one cause or	caused the death. I each line.	Do not enter the mode	of dying, such as cardi	ac or respiratory ar	rest,	Approximete Intervel Between
//	ysician Medicai aminer		immediete Cause (Final disease or condition resulting in death) e.	faute	Myoca s a consequence of): At the	rdial =	In farci	+	2 homs
		Jer		Due to (or as	s a consequence of):	C7 0:0	00.50		kan kan aran
cuted	physiclan and s tha burial-transit	Examiner			s a consequence of):	1 013	2002		an ion and
60, se axe	clan a		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Atheros	clerosis				unknown
ox 68760, cartificate be executed	CD 65	//Medical	that initiated events resulting in death) Last	Due to (or as	a consequence of):			,	
Box	a attandin d for usa	iciar	Part II. Other eignificant conditions contributing to	death but not reculting	on in the underlying cau	see given in Part I	23h Did	obacco usa con	tribute to the cause of death?
P.O.	igned by the s be datached	by Physician/M			, , ,				3 □ Probably 4 □ Unknown
of Vital Records, P.O. Box hysiclen: The law requires that the death cart	peen s	Completed t	Acute Brone	Litis			24a. Was perfo	an autopsy rmed?	24b. Were eutopsy findings available prior to completion of cause of death?
The la	paga 2	E OC					101	res 2 No	1 ☐ Yes 2 ☐ No
/ita	s cartificata ha director, paga	Be	25. Wes case referred to medical examiner?			1	eath (Check only o	ne)	
of Vita	- S % -	T.			/Outpatient 3□ DOA		Home 5 Resid		
	or: Affar th	Certification:	1 Accident S Pending (Mc	onth, Day Year)	b. Time of 28c Injury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No		now injury occurre	
Division To the Hospital or Attending	ins after death	Certifi	4 ☐ Homicide determined 206. Flat buil	ding, etc. (Specify)	e, farm, street, factory, o		City or Tow	vn, State)	er or Rural Route Number,
Hosp	within 24 hours at To the Funeral D complataly filled I	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the and many one)	ne best of my knowled basis of examination inner stated.	dge, deeth occurred at and/or investigation, in	the time, dete and place may opinion, death occ	e, and due to the curred et the time,	cause(s) and mar date and placa, a	ner as stated. nd due to the cause(s)
o the	To the	Me	29b. Signature and title of pertifier		29c. I	License number		29d. Date signed	(Month, Dey, Year)
	> F 0		Mark King	m.D.		D38024		3/5	1/98
4			30. Name and address of person who completed ca	use of death (Item 23	Ba) (Type, Print) Memo	rial H	losnita	1	
(6)	Sta Registr			Registrar's Signature		,	-//		

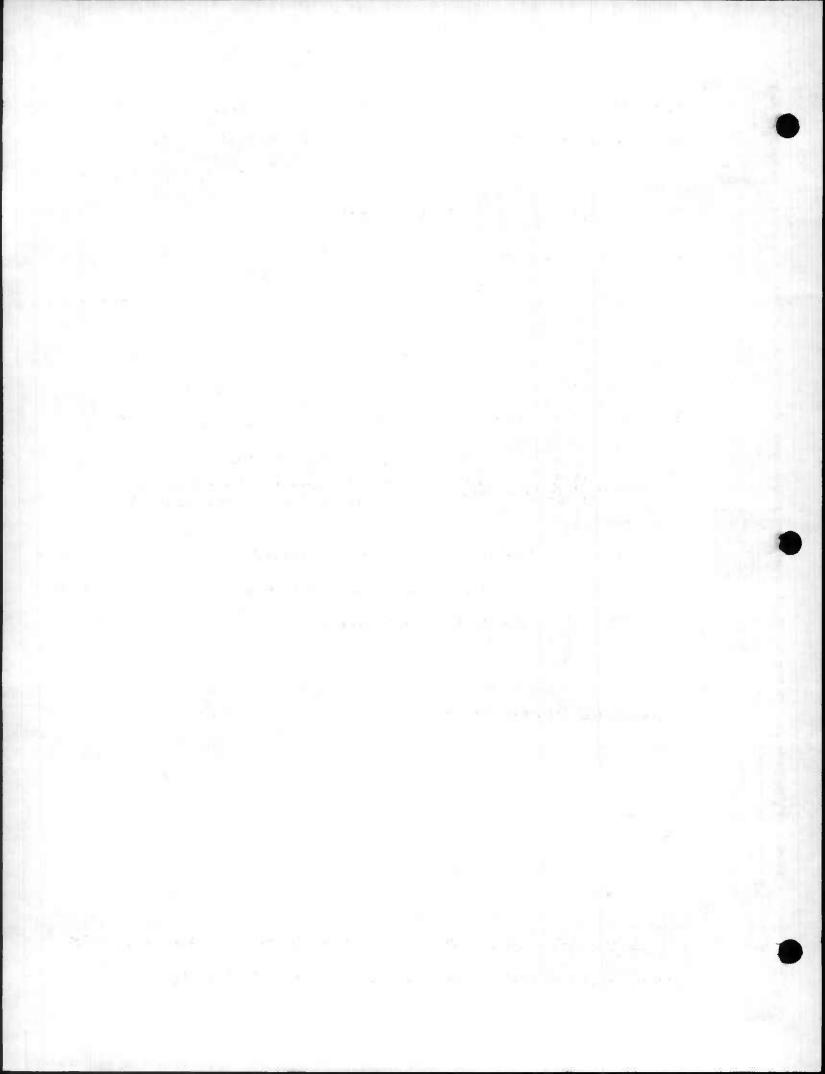


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/Medic		Peter T. Po	mpilo						MARC	471	1998	9	:304		
Examir		4e. Fecility Neme (If not institution, g						4b. City, Town, or L	ocation of Deet	h 4c. County	of Deeth				
		Union Memoria	A			Wife	4 14		imore		/ A				
Funeral Director		5. Social Security Number 300-12-2546 Usuel Residence of Decedent	. Sex 7. A 1 A M 2 □ F	72	lest birth Y	Months	Days	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De DEC 7,	1925	9. Birthol Count Ohio	lace (Stete itry)	or Foreign		
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iges 1 end 2 should be filled within 72 hours effer deeth with the Meryler it of Health and Mental Hygiene. And Health and Mental Hygiene. Or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Meritel Stetus 1 Never Married 2 Married Widowed 4 Divorced	Armed Forces 1 Yes 2 ff Yes, Give	2. Was Decedent Ever In U,S. Armed Forces? 10 Yes 2 D No If Yes, Give WW II Yeer or Dates:				lispenic Origin? (Sp en, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Raca - American In Bleck, White, etc. Specify: Whit					
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permit. Pages 1 end 2 Depertment of Health e Important: If item 27 is any injury or other tra once.		21. Signeture of Foneral Service Lic Dawn F. McDc 23a. Pert1. Enter the diseese, or co shock, or heert failure. List on	MARILIN	rald		Cromo	tion	Conjetir	of Mary	yland, I	nc. 21228	3			
		23a. Pert1. Enter the disease, or co shock, or heart failure. List on	mplications that caus ly one ceuse on eech	ed the deeth line.	n. Do no	ot enter the mod	de of dyir	ng, such es cardiac	or respiretory	errest,		Approxime Intervel Be	etween		
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	Certification:	3 ☐ Suicide 6 ☐ Could not determine		28f. Location (Street end Number or Rural Route Number, City or Town, Stete)											
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		30. Name and address of person wh			23a) (T	vne. Print)	, -	100	201 University PKW						
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State of Maryland / Department of Health and Mental Hygiene

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/Medical		RAMESH								1948	5:41 A						
Examiner		4a. Facility Nama (If not institution, giva straat and number) THE JOHNS HOPKINS HOSPITAL					4b. City, Town, or Loc BALTIMORE (t birthday) If Under 1 Year If Under 24 Hrs.					CITY N/		A			
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or items	5	11. Marital Status 1 ☐ Navar Marriad ②【☐ Ma 3 ☐ Widowad 4 ☐ Divorce	12. Was Dece Armed Fo 1 ☐ Yas If Yas, Giv Yaar or D	13 U,S.	13. Was Decedant of Hispanic Origin? (Spelf Yas, specify Cuban, Maxican, Puarto1 ☐ Yas 2 X No Specify:						Race - Amarican Indian, Black, Whita, atc. BootyAsian Indian						
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- CO		> I Wolfenden. M					D RES 000					March 5, 1998					
		30. Nama and address of person who completed causa of daath (Itam 23a) (Type, Print) LINDA WOLFENDEN. Johns Hopkins Hospital, 600 N. Wolfe St. Baltimore, M.															
State legistrar	1	31. Data filed (Month, Day, Yea MAR 1	-)	98 32. 1	The Di	Wasen-A	ande	82									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer Wildrad 3.30 A.L March 5 1998 4c. County of Dee 4a. Fecility Name (If not institution, giva straet end number) 4b. City, Town, or Location of Deeth Church Home Nursing Center Baltimore NA 5. Sociel Sacurity Numbar If Under 1 Yaar | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthpleca (Stete or Foreign Country) Deys 1□M 2□F 061-16-8731 Yrs 04-16-20 VA Usuel Residence of Decedent 10e Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits NA Baltimore X Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 201 North Broadway 21231 USA 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, atc. 1 Never Merried 2 Merried 1 ☐ Yes 21 No If Yes, Give Yaar or Detes: 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Black 15. Decedent's Education (Specify only highest grada completed) Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) 5th Grade Housewife in home 17. Fathar's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Thomas Jones Ruth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) 820 McCabe Avenue Baltimore, Maryland Ruthie Turner 20e. Method of Disposition 20b. Place of Disposition (Neme of camatery, cremetory or othar place) 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removal from State Voshell Mem. Gardens 03-09-98 Dundalk, Md. 4 ☐ Donetion 5 ☐ Other (Spacify) 21. Signeture of Funarel Service Licensee 22. Name end Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 D. North Avenue 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the a mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Immediete Cause (Finel diseese or condition resulting in death) Due to (or es e consequence of) arker Due to (or es a consequence of) Dua to (or es a consequence of): Pert tt. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🐙 Unknown 24a. Was en eutopsy performed?

Physician /Medical Examiner

signed by

After this certificate

Director

death

To the Hospital within 24 hours a To the Funeral C

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Completed

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Certification:

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Physician

/Medical

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Director

28a-f show ns 23a or 28a-f show

items ?

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"natural",

filed within 72 hours after

d 2 should be filed within 7 th and Mental Hygiene.

Pages 1 and 2 should be ment of Health and Mental ant: If Item 27 is marked our yor other traumatic events.

permit. Page Department of important: If any Injury or once.

21215-0020

Maryland

Baltimore,

Box 68760.

Records, P.O.

Division of Vital

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Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disaasa or Injury thet initiated events resulting in deeth) Last Physician/Medical

25. Wes cese referred to medical

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28b. Tima of

28a. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify)

24b. Were eutopsy findings available prior to completion of causa of death? 1 🗆 Yes 2/2 No 1 ☐ Yes 2 No

26. Plece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 □ Yes 2 □ No 28f. Location (Straet end Number or Rurel Route Number, City or Town, Stete)

12 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of examination end/or invastigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated.

28c. Injury at Work?

29b. Signature end title of certifier

1 Yes 2 No

5 Pending Investigation

6 Could not be determined

27. Menner of Death

1 Naturel 2 Accident

3 Sulcida

29e. Certifier

4 Homicide

(Check only one)

29c. License number

29d. Data signed (Month, Day, Year)

e end eddress of person who completed ceuse of death (ttem 23e) (Type, Print)

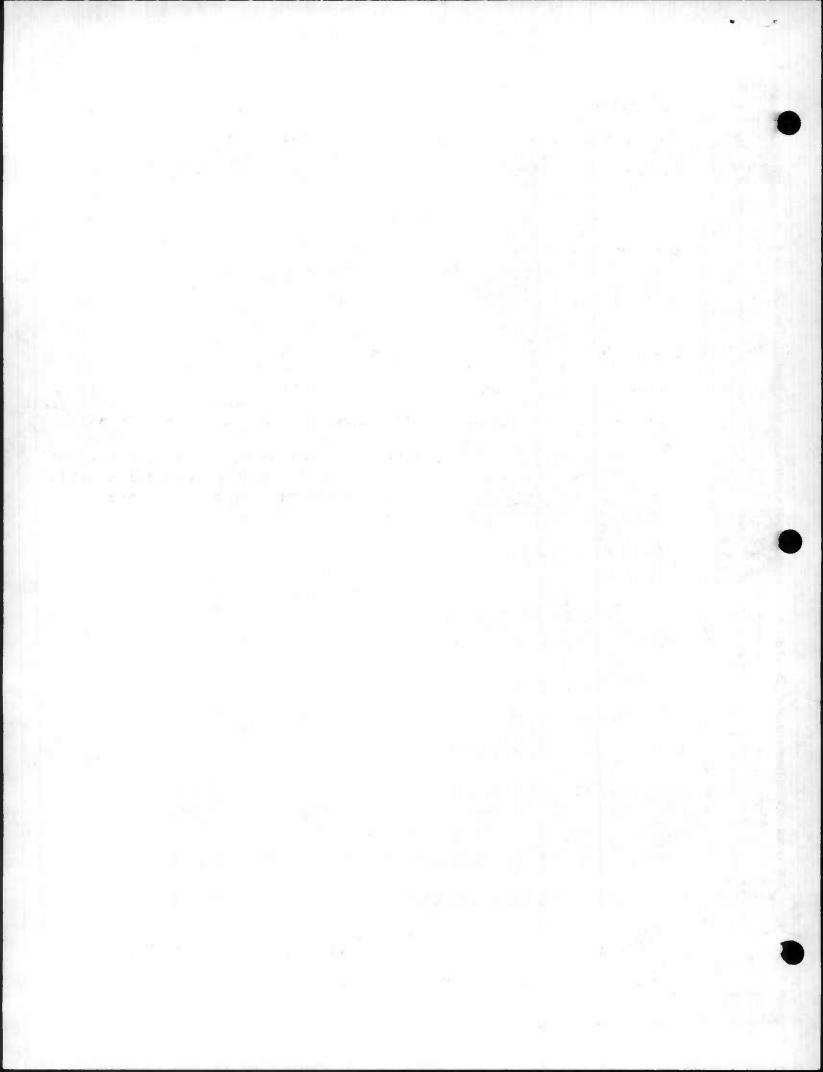
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28e. Dete of Injury (Month, Dey Year)

31. Dete fited (Month, Day,

32 Har strer's Signature

Registrar



220243942 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of User. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Year JEANETTE POWELL MARCH 10:30pm 1998 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital NA Balitmore If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 2√ K 77 Yrs. 220-24-3942 Director 02-04-21 Usuai Residence of Decedant 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Md. Director NA Baltimore NE Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 2709 Bookert Drive 21225 USA 238 Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes, 2 No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 'natural', or 1 ☐ Yes 2 2 No Specify: þ Specify: 3€ Widowed 4 □ Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elamantary/Secondary (0-12) Coilege (1-4or 5+) 10th Grade Cafeteria Aide Balto. Public Sch. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) Be Pages 1 and 2 should be Mary Charles Johnson Smith 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21225 19a. Informent's Name/Relationship (Type, Print) nt of Health and If item 27 is n or other traun Powell 924 Bridgeview Road Baltimore, Maryland 20c. Location - City or Town, State Md. 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition XBuriai 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 4 ☐ Donglion 5 ☐ Other (Specify) Cedar Hill Cemetery 03-09-98 Anne Arundel Co 22. Name end Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Lightsee WM.C.March FH 1101 E.North Avenue lar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final COPD disease or condition rasulting in death) Examiner Examiner ONGESTIVE HEART physician end s the buriel-trensit Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): LINE SEPSIS Physician/Medical Due to (or as e consequence of): use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 → Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveileble prior to Completed 24e. Was en eutopsy completion of ceuse of death? page 2 s 1 Yes 2 No 1 Yes 2 No certificete Be 25. Was cese referred to medicei 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) P 1 Yas 2 No 1-Impatient 2 ER/Outpetient 3 DOA the funeral di 28c. Injury at Work? 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred Certification: After 5 Panding investigation 1- Natural 2 Accident 3 ☐ Suicide

the death certificate be executed 68760 Box P.O. Records, Vita of Director: To the Hospital c within 24 hours of To the Funeral D completely filled.

21215-0020

altimore, Maryland

6 Could not be determined 28e. Place of Injury - At home, ferm, streat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rurel Route Number, City or Town, Stete) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, deta and piace, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, end due to the ceuse(s) and manner stated. (Check only one) 29b. Signature end tipe of cecilier 29c. License number 29d. Date signed (Month, Dey, Year)

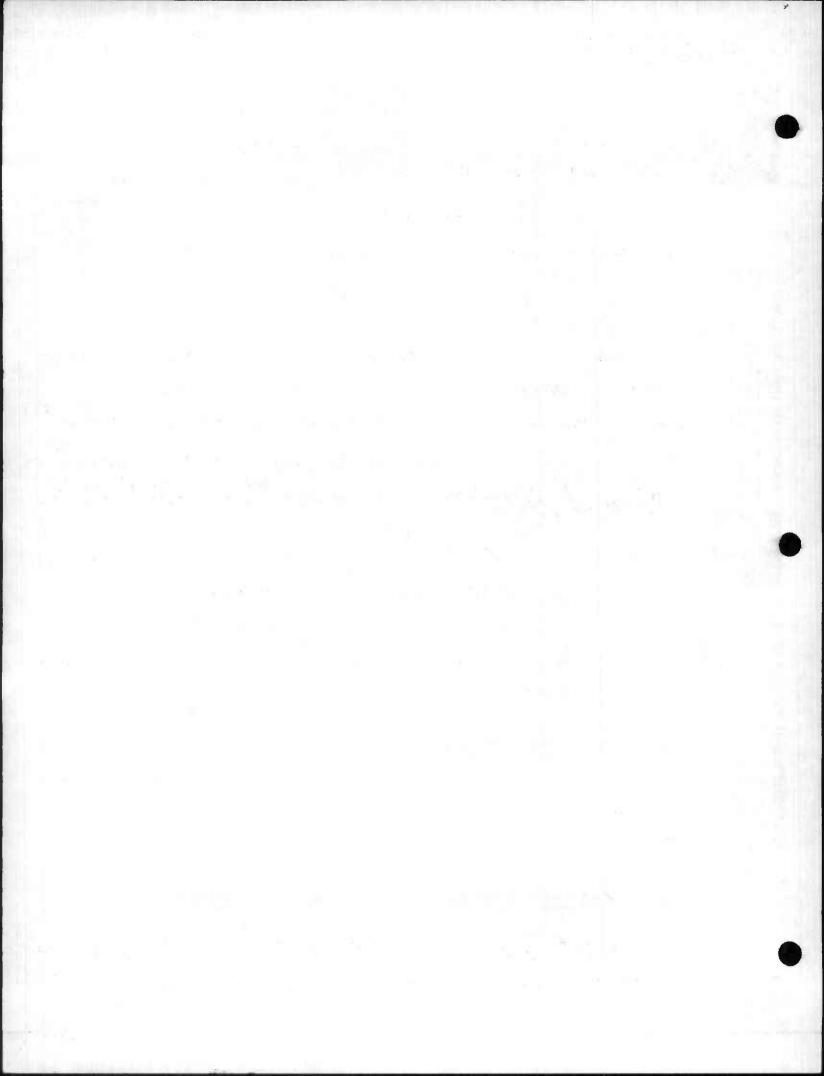
Registrar

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31. Date filed (Month, Dey, Year) MAR 1 0 1998

206HBI 6935 DONACHIE Rd APPG-BALTIMORE-MD 32. Registrar's Signature

30. Name end address of person who completed ceusa of death (Itam 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 0

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month March 7, 1998 Plumhoff 7:45am James Earl /Medical 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Edenwald Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Deys Hours 1 M 2 □ F Yrs 212-05-0626 Director April 22,1909 Maryland Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2X No Director Maryland Baltimore Towson Oe. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 238 800 Southerly Road 21286 USA Funeral Heme 12. Was Decedent Ever in U,S Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify by 3 Widowed 4 ☐ Divorced "natural", White Completed 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) 12 Communications n/a Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) 2 should be fi and Mental H Is marked off Be Frederick Plumhoff Mary Elizabeth Johnson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 67 permit. Pages 1 and 2 Department of Haalth an Important: If Item 27 Is any Injury or other trau 205 Patann Road, Timonium, Maryland 21093 Mary Ellen Menzel/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other placematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ACremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Baltimore-Washington 3/9/98 Laurel, Maryland 21. Signature of Fuperal Service Licenau 22. Name and Address of Facility Clary Lemmon Funeral Home Bryan 10 W. Padonia Road, Timonium, Maryland 21093 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Interval Between Onset end Death **Physician** /Medicai Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medicai phys Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Dtd tobecco use contribute to the cause of death? 1 Yes 2 No been signed by should be detac 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings available prior to Completed 24e. Was en eutopsy performed? completion of cause of deeth? page 2 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No certificata Division of Vital To the Mospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 XNaturai 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. Medicai Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. 29b. Signature and title of cartifie 29c. License number 29d. Date signed (Month, Day, Year) March 9, 1998 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) Marcelino Albuerne, MD 516 N. Rolling Road, Baltimore, MD 31. Date filed (Month, Day, Yeer) 32 Facistrar's Signature State

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indeible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7468 Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Data of Death Month 1.250n Walter F. Pumphrey MRCh 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) TEN BURNIE If Under 24 Hrs. 8. Date of B COUNT Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 1₩ M 2□ F Days Hours Min. Yrs. Maryland 219-14-2429 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21060 100 Prospect Road 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Dyes 2 DNo WWII If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Widowed 4 □ Divorced 15. Decedant's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) H.W.Flori & Sons Carpenter 10 N/A 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Erma G. Pumphrey Walter L. Pumphrey 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 206 Sycamore Road Baltimore, Maryland 21226 Deborah O'Connell Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park March 11,1998 Glen Burnie, Maryland 4 Donation 5 DOthar (Spacify) 21. Signatura of Funerai Sarvice License 22. Name and Addrass of Facility McCully-Polyniak Funeral Home no 3204 Mountain Road Pasadena, Maryland 21122 23. Fart1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediate Cause (Final disease or condition rasulting in daath) 2 Welks reumonia Dua to (or as a consequence of): (Welk ARCINOMA Sequentially list conditions, if any, leading to immadiate ceuse. Entar Underlying Causa (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): nonic, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown ATRIAL - FIBRILLATION 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ 110 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28a. Date of injury (Month, Day Year) 27. Mannar of Death 28d Dascribe how Injury occurred 28h Time of 28c. Injury at Work? 5 Pending Investigation 1 PNatural 1 ☐ Yes 2 ☐ No 2 Accident

Examiner Examine Division of Vital Records, P.O. Box 68760 88 use signed by d be detacl irector, page 2 s this funeral After or Attending death. ector: / à 24 hours after to Funeral Directions of Funeral Directions of the Funeral Direction of the Funer

Physician

/Medical

Examiner

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r than "natural", or items 23s or the Medical Examiner must be r

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Mental

Pages 1 and 2

item 27

Physician

/Medical

UPLIER F. PURCHEL

Physician/Medical þ Completed Be 9 Certification: edical

3 ☐ Suicide

29a. Cartifier

4 | Homicide

(Check only one)

29b. Signature and title of certifier

To the Vithin 2

Registrar

29c. Licansa number

Place of injury - At home, farm, streat, factory, office building, atc. (Spacify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

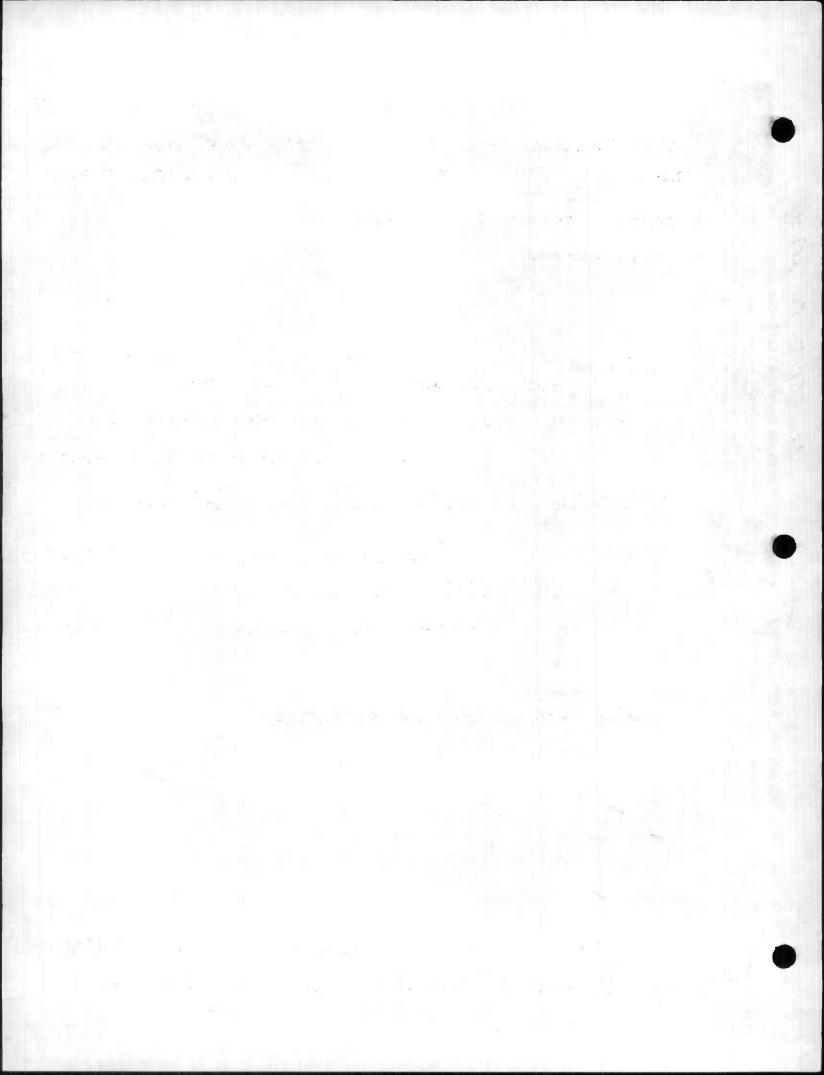
mD 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to tha causa(s) and mannar as stated.

Hozor tzul Clen Bourne. mo. Ance

31. Daje filed (Month, Day, Year) MAR 1 0 1998

6 Could not be detarmined



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** 0000 BLANCHE ROBINS mard /Medical 4a. Fecility Nema (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** UNION MEMORIAL HOSPITAL N/A BALTIMORE
If Under 1 Yeer | If Under 24 Hrs. | 8, Det 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthpleca (Stata or Foreign Country) **Funeral** 1 M 2 □ F Deys Min. 061-07-7767 Yrs. 83 Director DEC. 31,1914 NEW YORK Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f ehow Examiner maint be notified at 1 Yes 2 No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21211 USA Funeral 830 W. 40th ST 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Yaar or Dates: Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 11. Marital Status 1 Never Married 2 ☐ Married 21215-0020 1 ☐ Yes Y No Specify: "natural", or þ 3 Widowed 4 Divorced Specify WHITE Completed the Medical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 end 2 should be annot of Health end Mental MICHAEL HARTMAN LENA 19e. Informent's Name/Reletionship (Type, Print) permit. Pages 1 end 2 sh Department of Health end Important: If Item 27 is m any Injury or other traum once. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MS. LUCY ROBINS (DAUGHTER) 2309 KEN OAK ROAD BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MT ZION 3-9-1998 MASPETH, QUEENS, N.Y. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Address of Fecility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208 e, or come cations thet caused tha daath. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Physician/Medical Examiner weel Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events rasulting in death) Lest 68760 the USe as Box Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably Dunknown þ Records, 24b. Ware autopsy findings evelleble prior to complation of cause of deeth? Be Completed 24a. Wes en eutopsy 1 Yes certificate of Vital 25 Ves cese referred to medicel xeminer? 26. Piece of Death (Check only one) Hospitel: 1 / Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No Certification: To 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Division or Attending Nature 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: A in by the f 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours edicai Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the best of examination end/or investigetion, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 13 completed cause of deeth (Item 23a) (Type, Print) 30. Name end eddress of person

Paca

32. Registrar's 6igns

State

Registrar

31. Data filed (Month, Day, Yaar)

MAR 1 0 1998

Rate while and page 11 that

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) **Physician** BERNARD RIEGER /Medical 4e. Fecility Neme (If not institution, give street end number) Examiner Sinai Hospital of Baltimore 5. Social Sacurity Number 7. Age (In yrs. lest birthday) **Funeral** 1√ M 2□ F 72 128-14-4695 Yrs Director

March 4b. City, Town, or Location of Death City Baltimore

Vaai 1948 820 AM 4c. County of Deeth

3. Time of Death

1 Yas No

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | FEB. 18,

2. Data of Death

Month

9. Birthplace (State or Foreign

Usual Rasidance of Decedant 10a State 10b. County

10c. City, Town or Location

1926 NEW YORK 10d. Insida City Limits

MARYLAND

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0020

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7 is marked other than "natural", or itema 23s or traumatic event, the Medical Examples right be re-

Hygiena.

permit. Pages I and 2 should be file Department of Health and Mentel Hy, Important: If Itam 27 ie marked othe eny Injury or other traumatic event, page.

Physician /Medical

Examiner

physician

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been signed by the should be deteched

certificate

director

funeral

completely To the To the To the

I or Attending Physician: after death. Director: After this certifica

Mospital of 24 hours a Funeral D

Division of Vital Records,

Examiner

Physician/Medical

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Completed

Be

Medical

Director

Funeral

by

BALTIMORE

BALTIMORE

10f. Zip Coda

10g. Citizen of What Country?

USA

10e. Street end Number 3819 BUCKINGHAM RD.

1 Never Married 2 Married

12. Wes Decedant Evar in U,S. Armed Forcas? 1 Yes 2 □ No If Yas, Giva Yaar or Datas:

 $5\pm$

 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 No Specify:

21207

14. Race - American Indian, Black, Whita, atc. Specify: WHITE

IITRI

3 ☐ Widowed 4 ☐ Divorced

20a. Mathod of Disposition

15. Decedant's Education (Specify only highest grede completed) Elementery/Secondery (0-12) Collega (1-4or 5+)

16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Businass/Industry

17, Fathar's Name (First, Middle, Last)

ABRAHAM

18. Mothar's Nama (First, Middle, Maiden Sumeme)

NETTIE **JOSEPH**

19a. Informant's Name/Ralationship (Type, Print)

MRS. MIRIAM RIEGER (WIFE)

19b. Meiling Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 3819 BUCKINGHAM RD. BALTIMORE, MD 21207

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, Stata

ELECTRICAL ENGINEER

1 ☐ Burlel 2 ☐ Crametion 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lide

BETH EL MEMORIAL PARK - 3-8-1998 RANDALLSTOWN, MD 21133 22. Nama and Address of Facility
Sol Levinson & Bros., Inc.

8900 Reisterstown Road Pikesville, MD 21208

disaasa, or complications that causad tha daath. Do not anter the mode of dylng, such as cerdiac or raspiratory arrast, ailura. List only one cause on each line.

RIEGER

Onset and Death

Immediata Causa (Finai diseesa or condition resulting in death)

Chronic lymphocytic Leukemia Dua to (or as a consequence of)

30 yrs

Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated evants rasulting in daath) Last

Due to (or as a consequence of)

Dua to (or es e consequança of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobscco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

24b. Wara sutopsy findings available prior to

completion of cause of dasth?

26. Placa of Death (Check only one)

25. Was casa rafarred to madical 1 Yas 2 No

5 Pending investigation

6 Could not be datarmined

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Tima of

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28c. Injury et Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, straet, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one)

27. Mennar of Death

Natural

2 Accidant

3 Sulcida

4 Homleide

1 Certifying Phyeician: To the best of my knowledga, death occurred at tha time, dete end piece, end due to tha ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the tima, deta and place, end due to tha cause(s) end mannar stated. 29c. License number 29d. Data signed (Month, Dey, Year)

29b. Signatura and title of certifiar

1 0 1998

D2402321HB9517 March 7

30. Nema and addrass of person who complated cause of death (Item 23e) (Type, Print)

31. Data filad (Month, Dey, Year)

Sinai Hospital of Baltimore 32 Registra's Signature Tandall

State Registrar

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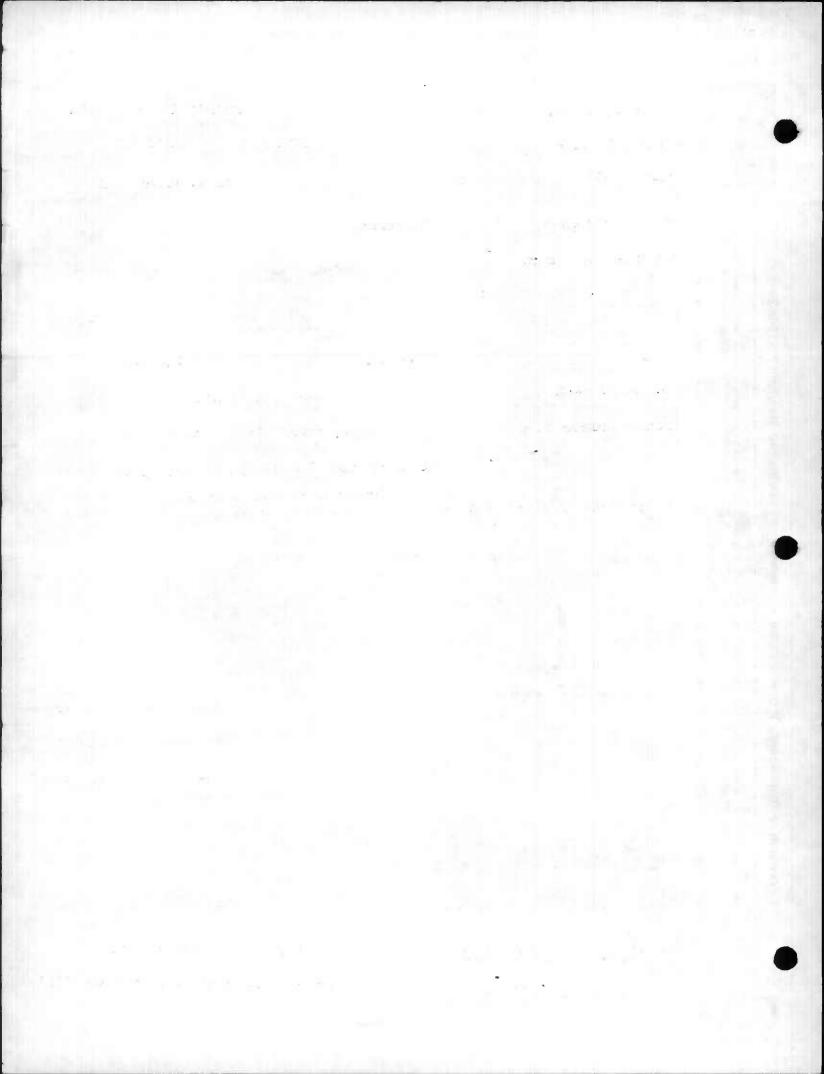
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 8 9 7 1 7 1

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or	218- Usual Resi	-78-23		1□ M	4 ₹ F	25	Yrs.	Months Days	s Hours Mir			.972d	MD	Y)
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Be			irst, Middle,						18. Mother's N	ime (<i>First, Mil</i> d	ile, Melo	en sumam	10)	
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			Other (S)			Re	stlawn M	emorial	Gardens ress of Facility	03/05	La	Vale	MD	
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	.,	Enter the k, or heart Ceuse (Fi	disease, or failure. List	complicationly one of		ED DRUG	ath. Do not enter	the mode of d	Li Funera and MD 21 ying, such as card COMPLICATI	502 of respirator	P.A	Α.	1	Approximate nterval Between Onset and Death
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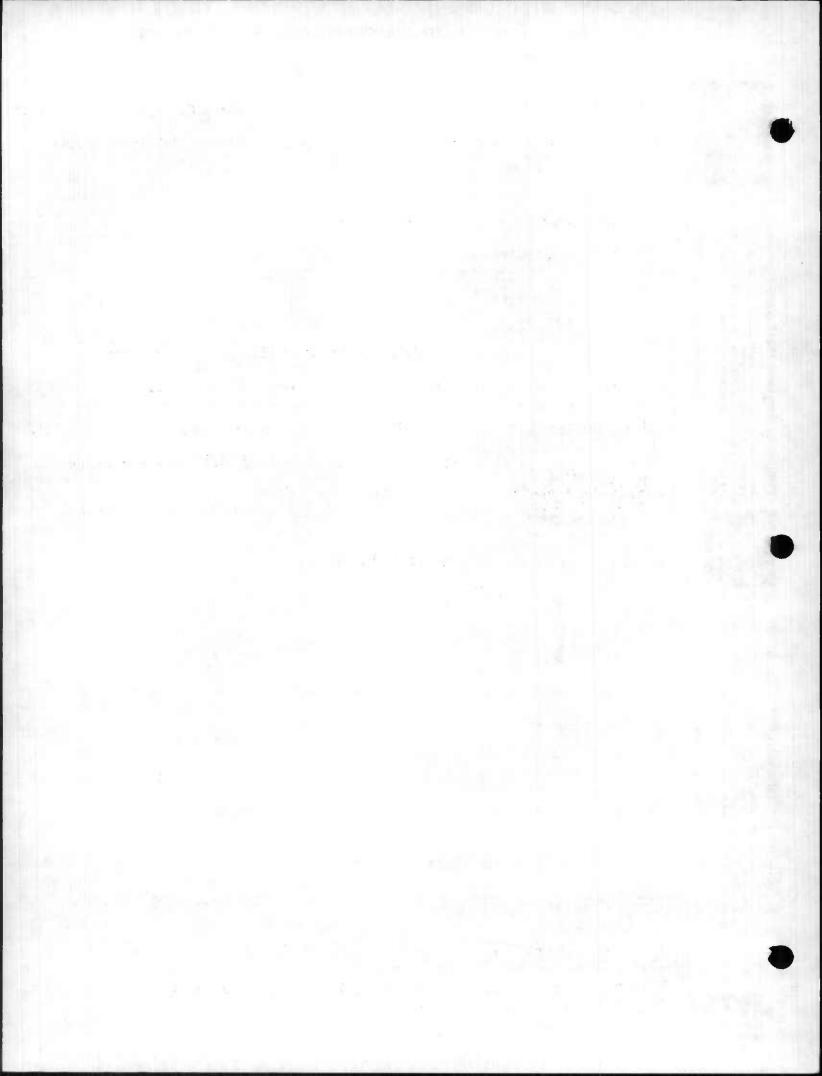
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ELIZABETH RAY March 6, 1998 5:25 AM /Medical Baptist Home of Maryland and Delaware Owings Mills Ba

7. Age (In yrs. lest birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Name (If not institution, give street end number) Examiner Baltimore County 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign March 18, 1902 Missouri 5. Social Security Number **Funeral** 1□M 2₩F 95 Yrs. 220-44-7765 Director Usual Residence of Decedent with the Marylence r 28a-f show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore County Owings Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or itema 23a or treumatic event, the Modical Examiner numbers 10729 Park Heights Avenue permit. Pages 1 and 2 should be filed within 72 hours efter death v
Department of Health and Mental Hygiens.
Important: If item 27 is marked other than "natural", or items 23a
and injury or other treumatic event, the Medical Examiner and page. 21117 **IISA** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: 1 X Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Dept. of Labor and Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Supervisor 12 years Statistics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Marion Ray Mary Ellen Hall 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cametery, crematory or other place)

20b. Place of Disposition (Name of cametery, crematory or other place) Keith Bryan, (Asst. Adm.) 20a. Method of Disposition 1 XBuriel 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 3/11/98 Bladensburg, MD Lincoln Cemetery 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility artino Mitchell-Wiedefeld Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Maryland 21212 approximate shock, or hear failure. List only one cause on each line. Interval Between Onset end Death **Physician** /Medical immediate Cause (Final disease or condition resulting in deeth) Coronary Artery Disease Examiner Due to (or as a consequence of): Examiner ASCVD physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. certificate be Physician/Medical Due to (or as a consequence of): 85 980 ò 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed t Division of Vital Records, Ď, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed certificete has **pege 2** 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No After this 28e. Dete of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 5 Pending ors after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signatura and title of certifier 3.7.98 an 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Theodore C. Houk, M.D., 7825 York Road, Towson, Maryland 21286
Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) MAR 1 0 1998 State MAR Registrar

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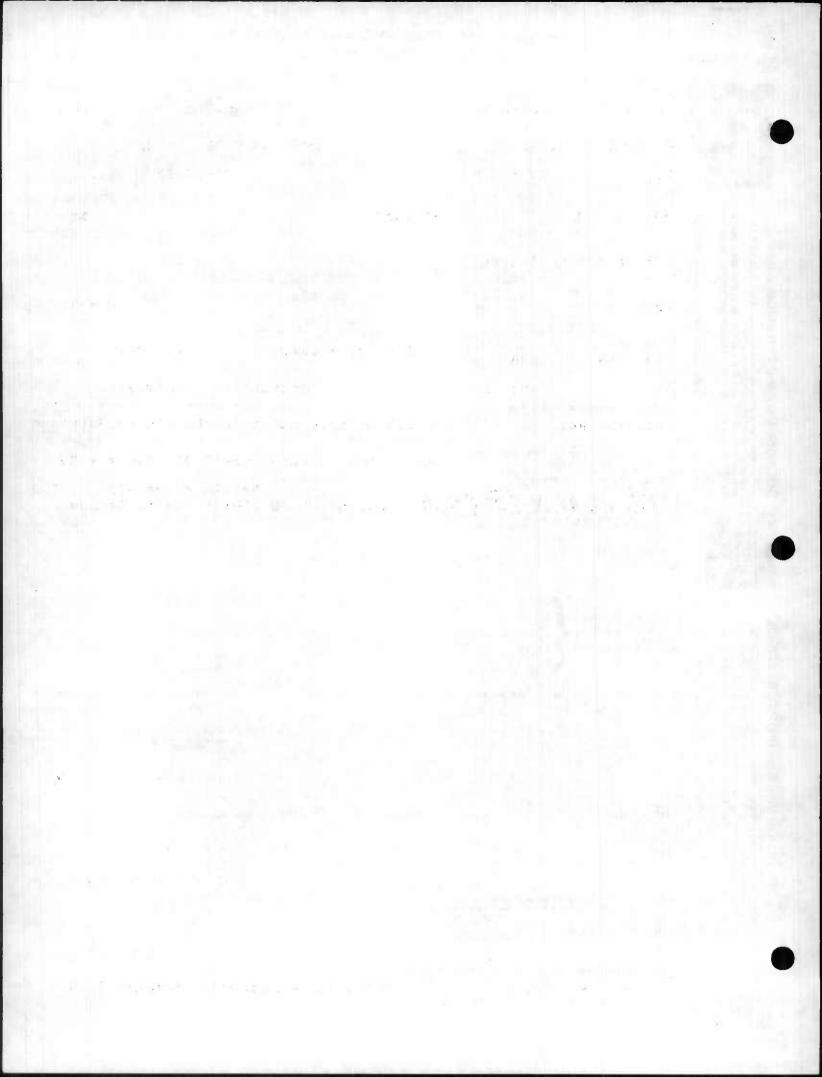
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State Registrar

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32. Registrar's Signeture



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MARGARET

/Medical Examiner

3. Time of Deeth

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9:20A.M.

Funeral Director

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certificate has Hospital or Attanding Physician: this lunerel After 24 hours after death. filled in by within 2

item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Experies must be notified at Director Funeral Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene. altimore, Maryland 21215-0020 by Completed Be P any Injury Physician /Medical Examiner Examiner Physician/Medical Division of Vital Records, þ Completed Be 2 Certification: Medical

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH 04, 1998 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) E.BALTIMORE STREET BALTIMORE A 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Year) 1□M 2 F Months Days Hours 318-14-8414 Usuel Residence of Decedent Yrs. 10d. Inside City Limits 10a. Stete 10b. County 10c. City. Town or Location 1 Yes 2□No MD ALTIMORE 10e. Street and Number 10g. Citizen of Whet Country? 690 PALTIMORE 57. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1□Yes 2 No Specify: 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) UTTER 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) ANNA HIL 10033 ABOD DALTIMORE 20b. Piece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Pown, State 1 Buriel 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) EARTOF 23a. Part1. Enter the disagraph or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? INSPECTION 1 ☐ Yes 25 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1□Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27 Manner of Death 28c. Injury et Work? 28b. Time of 1 Naturel

5 Pending investigation 2 Accident 3 ☐ Suicide

6 Could not be determined 4 Homicide

28a. Dete of Injury (Month, Dey Year)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated. 29c. License number 29d. Dete signed (Month, Day, Year)

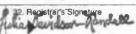
lan 30. Name and address of person who completed cause of death litem 23e) (Type, Print)

O.C.M.E.

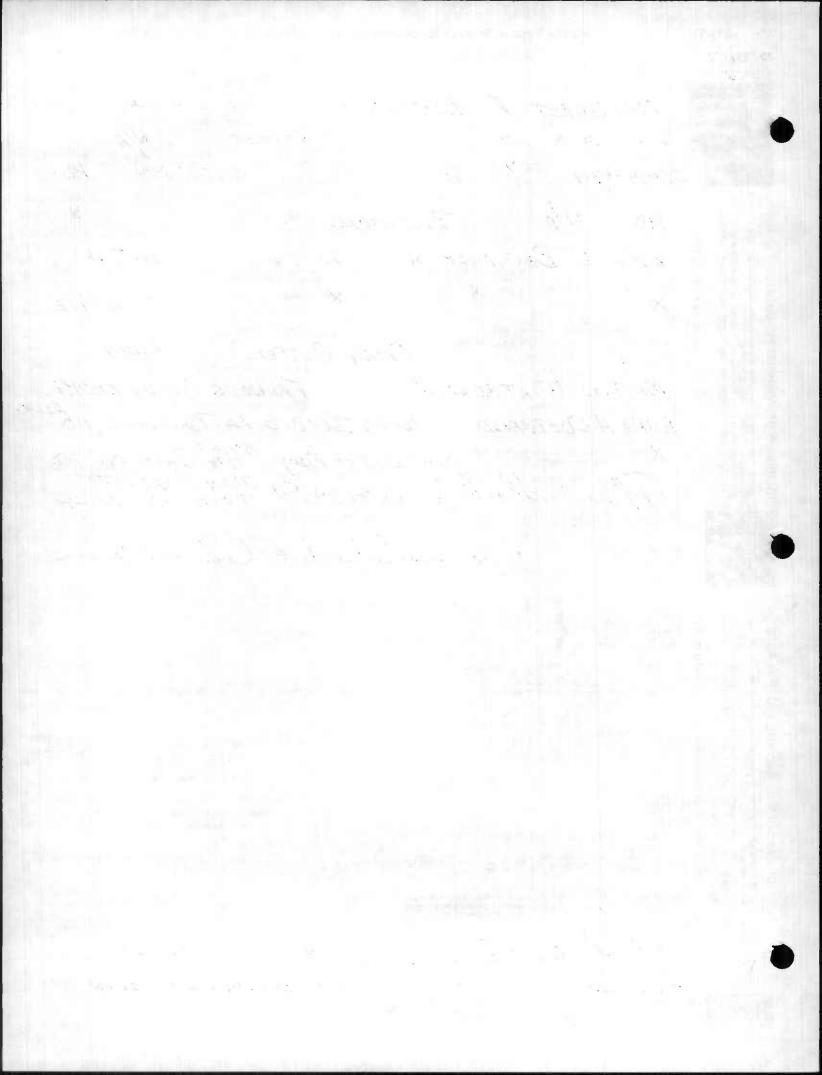
MARCH 4.1998

111 Penn Street, Baltimore, Maryland 21201

Theodore King M.D. 31. Date filed (Month, Day, Year)

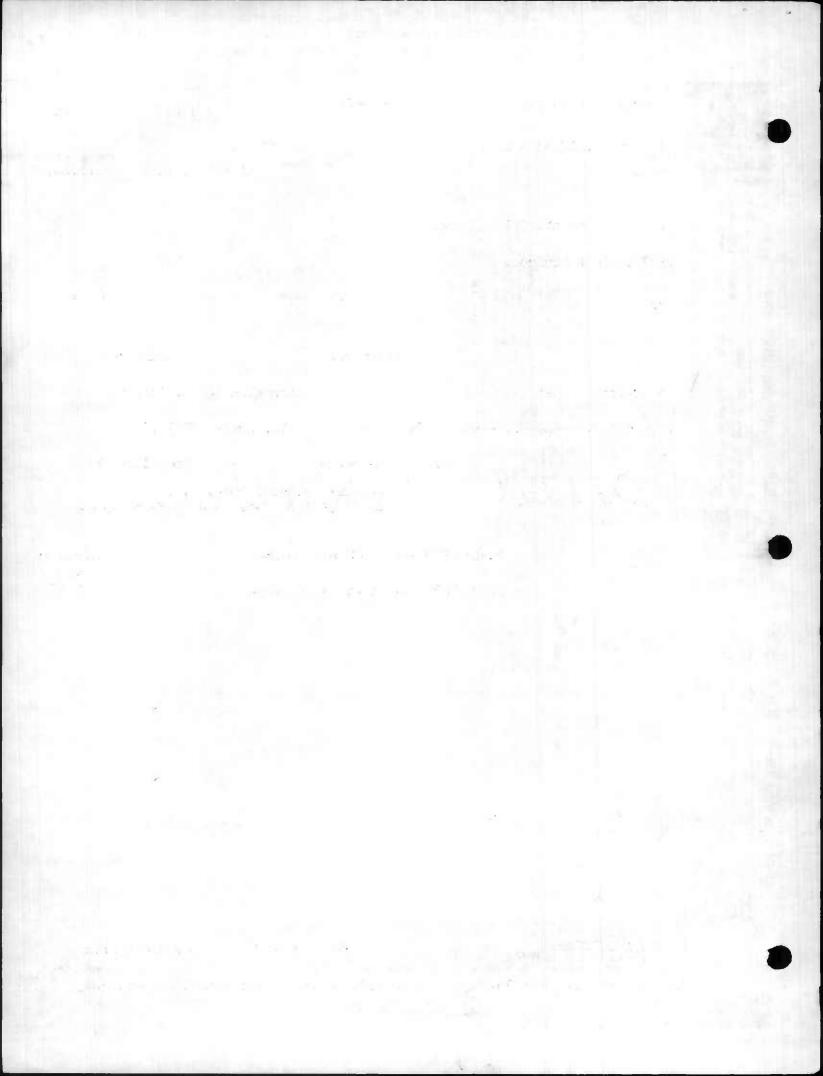


State Registrar



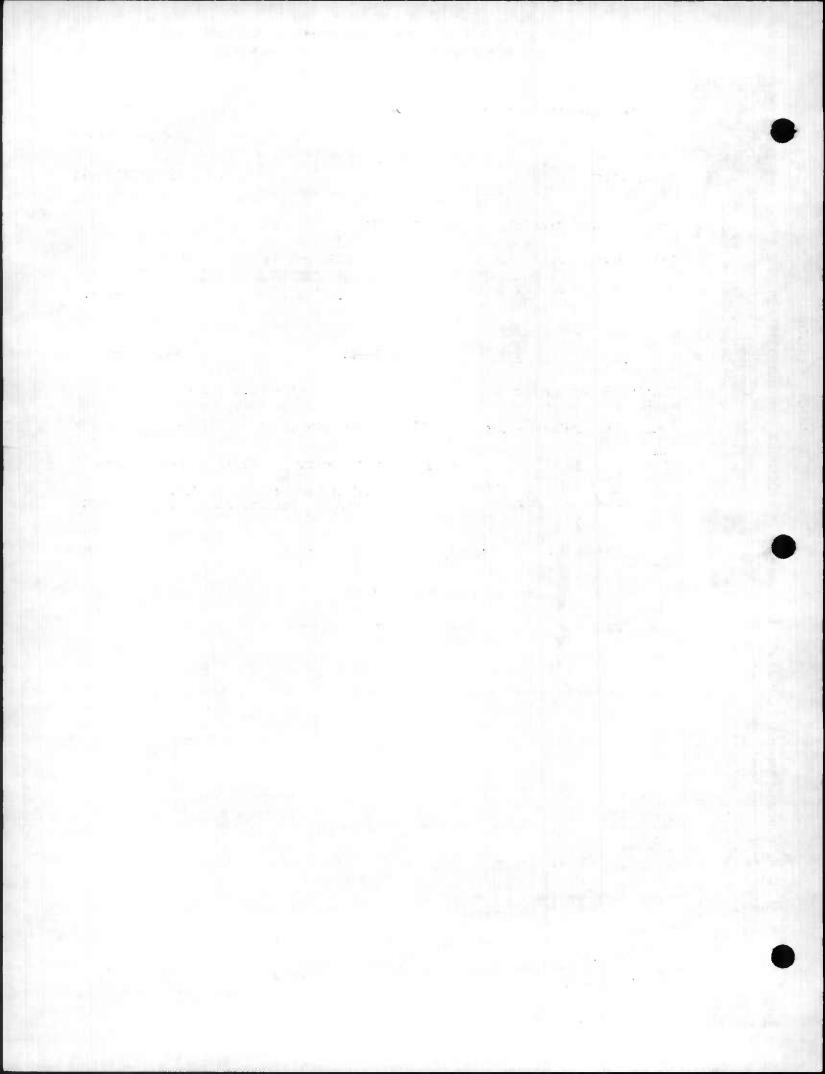
Item: 19a Per FH Film G-757 3-17-98RC Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Dey **Physician** REED MARGUERITE MARCH 9,1998 3:46AM/Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY

If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Day, Year)
April 7, 1918 Washington, DC If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign **Funeral** 1 M 2 F Months Days Yrs. 79 578-42-0508 Director Usual Residence of Decedent tha Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or items 23s or 28s-f show the Medical Essenies must be notified at 1 ☐ Yes 2 No Directo MD Anne Arundel Deale 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with permit. Pegas 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. In proceeding the marked other than "naturel, or flems 23 any Injury or other treumatic event, the Medical Exercises 200. USA 14. Race - American Indian, Funeral 5927 Deale Beach Road 20751 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 White Specify: þ 3√Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life, DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Homemaker 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) 2 Roy Clifton Frost Catherine Louise Schultz 19a. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LAWRENCE H. REED, 5927 Deale Beach Rd, Deale, MD 20751 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete XX Buriai 2 Cremetion 3 Removel trom State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery 03/12 Rockville, MD 21. Signeture of Furiery Service Licensee 22. Name end Address of Fecility Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,
Approximately 1. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final MYOCARDIAL INFARCTION TWO HOURS disease or condition resulting in deeth) Examiner Due to (or es e consequence of): TWENTY Examiner CORONARY ARTERY DISEASE YEARS The law requires that the death cartificete be executed physician and s the buriel-trans Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence ot): ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records, by 24b. Were autopsy tindings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy peen has a 2 paga 200 No 1 Yes 1 ☐ Yes 2 ☐ No cartificata After this cartification, I Attending Physician: Be 25. Wes case referred to medical examiner? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1☐ Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 1 Neturel 5 Pending daath. 1 ☐ Yes 2 ☐ No Investigation after death 2 Accident 6 Could not be determined 3 Sulcide 28e. Pieca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai 2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number RES-000 MARCH 9, 1998 MO 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) MARYLAND 21287 KARI E - ROBERTS. MO TOWER 110, JOHNS HOREINS HOSPITAL, 600 N. WOLFEST., BALTIMORE, 31. Date filed (Month, Day, Year) wie Dandson-Randwa State Registrar



Please Type or Print in Black Indelible Ink. Assu	re All Copies Are Legible
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Items: 16a, b per FH G-757 3/27/98 dh 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 7:25 PM 1998 MARCH Norman Rhinehart Reiland /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Examiner GLENBURNIE ANNEARUNDEL NORTH ARUNDEL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 12 M 2 ☐ F 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Yrs. Nov. 4, 1922 Illinois Director 334-14-6748
Usuel Residence of Decedent the Meryland 10d. Inside City Limits r 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 1 Yes 2 No Director MD Millersville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 1539 Severn Chapel Road 21108 Funeral 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 ☐ No If Yes, Give Year or Detes: 14. Race - American Indien, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Bleck, White, etc. 1 Never Merried 20XMarried Specify: White 1 ☐ Yes 2 No altimore, Maryland 21215-0020 Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion
(Give kind of work done during most of working life, DO NOT use retired)
Signals Research Tech.
Enlisted Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) National Security Agency U.S. Navy 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event bloce. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Nina Gertrude Renz Charles Peter Reiland 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) PO Box 756, Gambrills, MD 21054 Robin John Reiland - Son 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition XXBuriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 03/11 Crownsville, MD MD Veterans Cemetery 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Hardesty Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximately 12 Ridgely Avenue, Annapolis, MD 21401 shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final MYOCARDIAL INFARCTION disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner CORONARY ARTERY DISCASE physician and the bunal-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequence of): 10 YEARS Vital Records, P.O. Box 68760, HYPERTENSION Physician/Medical Due to (or es e consequence of): for use as signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 → tinknown by 24b. Were eutopsy findings availeble prior to completion of cause of deeth? been si Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No certificate 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 | Yes 2 | -Mo 1 Impatient 2 ER/Outpatient 3 DOA to 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending 1 [Heature] 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. ş 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number 0 BC 5572195 MARCH 7 11998 HOUSE STAFF MEDICINE Michaety 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) MD 21061 GLENBURNIE BINU CHACKO 301 HOSPITAL DRIVE 32 Hammar Stonature Andoll 31. Dete filed (Month, Day, Year) State MAR 1 0 1998 Registrar



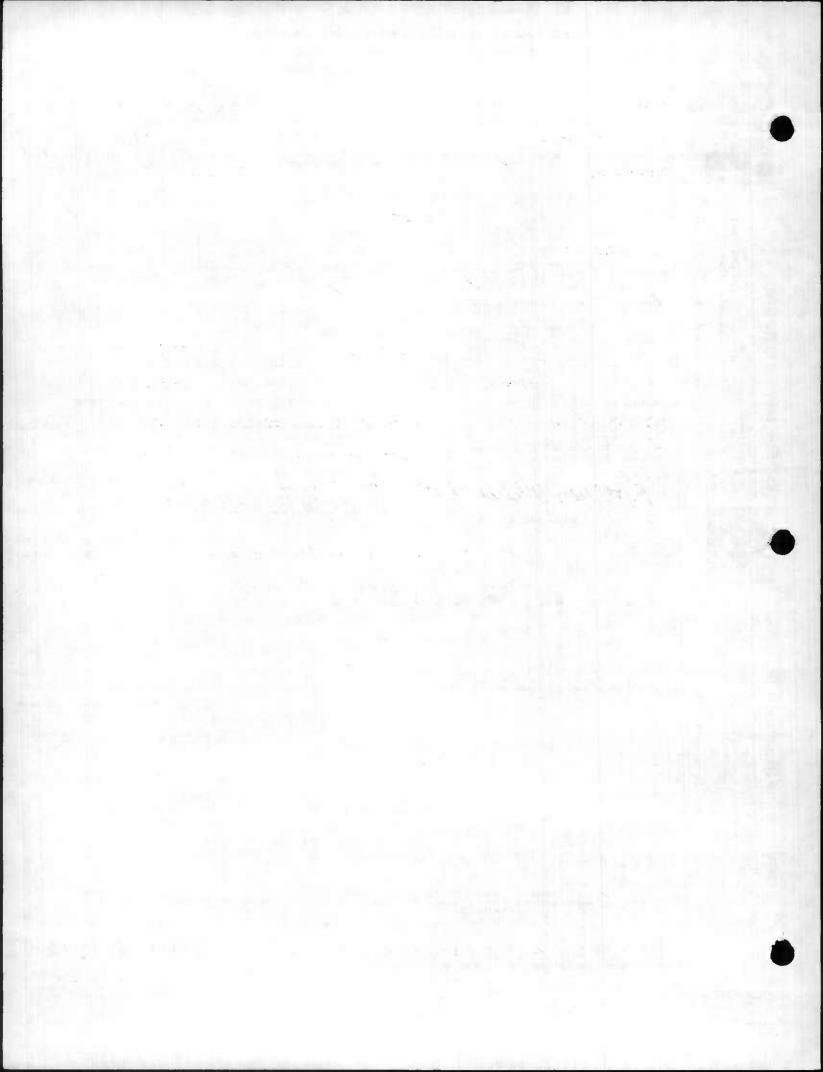
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Anna Rewers February 19 1998 11:20AM /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner 525 S. Ann Street Baltimore N/ A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthpiace (State or Foreign Country) **Funeral** 1 M 2 F Months 216-01-4688 84 Director 10/06/1913 MD Usuei Residence of Decedent tha Marylend 10c. City, Town or Location 10e. Stete 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Essent or must be nothled as 1 Yes 2 No MD Baltimore Directo 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 525 S. Ann Street 21231 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Pegas 1 and 2 should be filed within 72 hours after enent of Hastilk and Mental Hygiane.
nt: If item 27 is marked other than "natural", or item yor other traumatic event, in Medical 1 ☐ Yes 2 ☑ No It Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White by 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Masseuse Healthcare 6 17. Fether's Nema (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Witold Browski Josephine Szatkowski 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Helen Christesen/sister 2126 Bank Street Baltimore Md. 21231 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removal from State permit. Pega Department of Important: If any injury or once. St. Stanislaus Cemetery 3/3 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Md 21. Signature Funeral Service Licenses 22. Name end Address of Facility David J. Weber Funeral Home 401 S. Chester Street Baltimore Md. 21231 Approximete Intervel Between Onset and Death 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart tailure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical myocardial manediak Examiner Due to (or as a consequence of): Examiner disease en years Coronary artery physician and s the burial-transit that the death cartificete be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): * Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): attending pl signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy tindings avellable prior to Completed 24e. Was en eutopsy completion of cause of death? certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Wes case reterred to medical examiner? Be 28. Place of Death (Check only one) To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) funaral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Hospital of attending P n 24 hospital death.

Funeral Discipir: After to fataly filled in by the funeral 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner es steted.

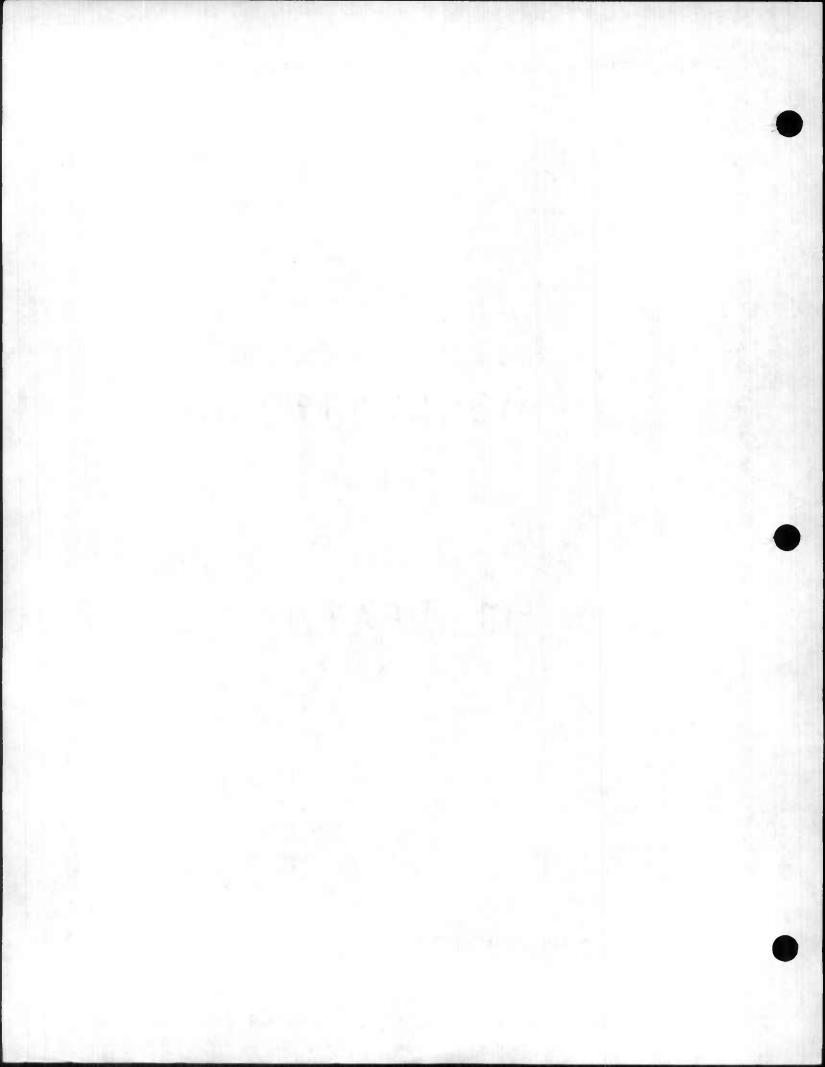
| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fund complately f (Check only one) 29b. Signature end title ot certitier 29c. License number 29d. Dete signed (Month, Dey, Year) Brook, 043636 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rodney W. Prooks, MD. 3411 Ban BANK St. BAltimore MO. 31. Date filed (Month, Dev. Year) State 0

Registrar



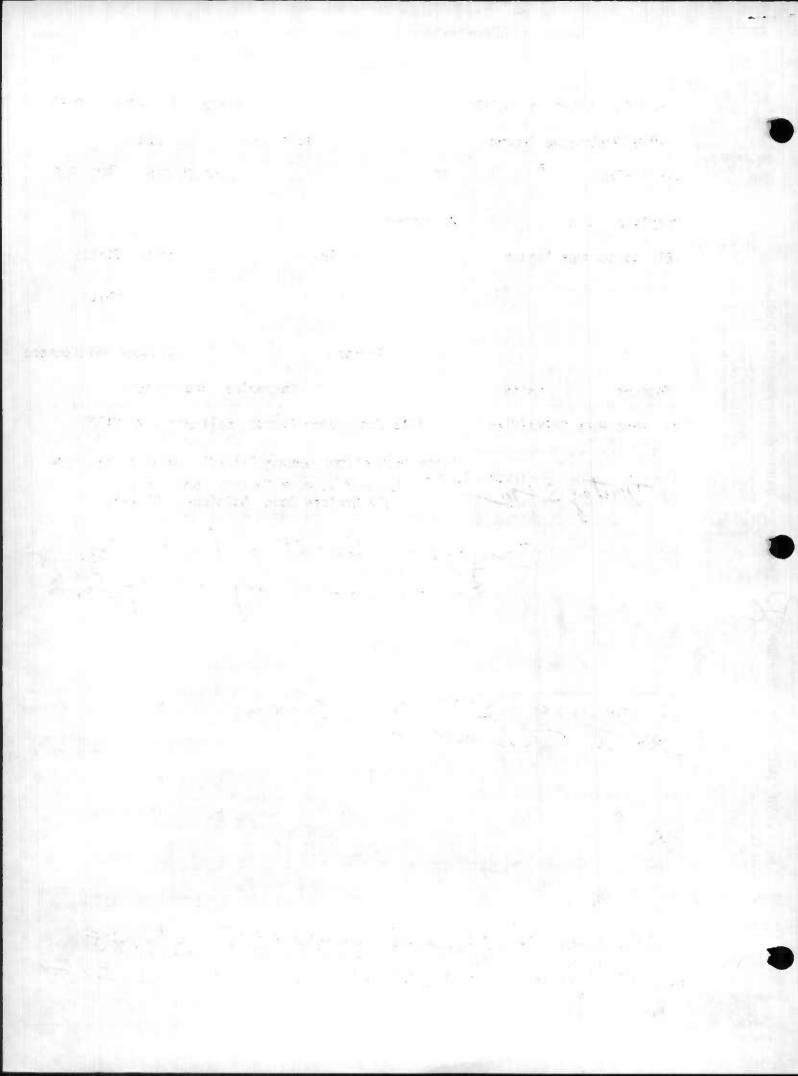
VOID
CERTIFICATE #
98-07478
SEE
CERTIFICATE #
97-DEATH

likapri padiki pakiki kalan kung terapi di kababan kung panjakan kalan kilika kaliki (kakiki 194)



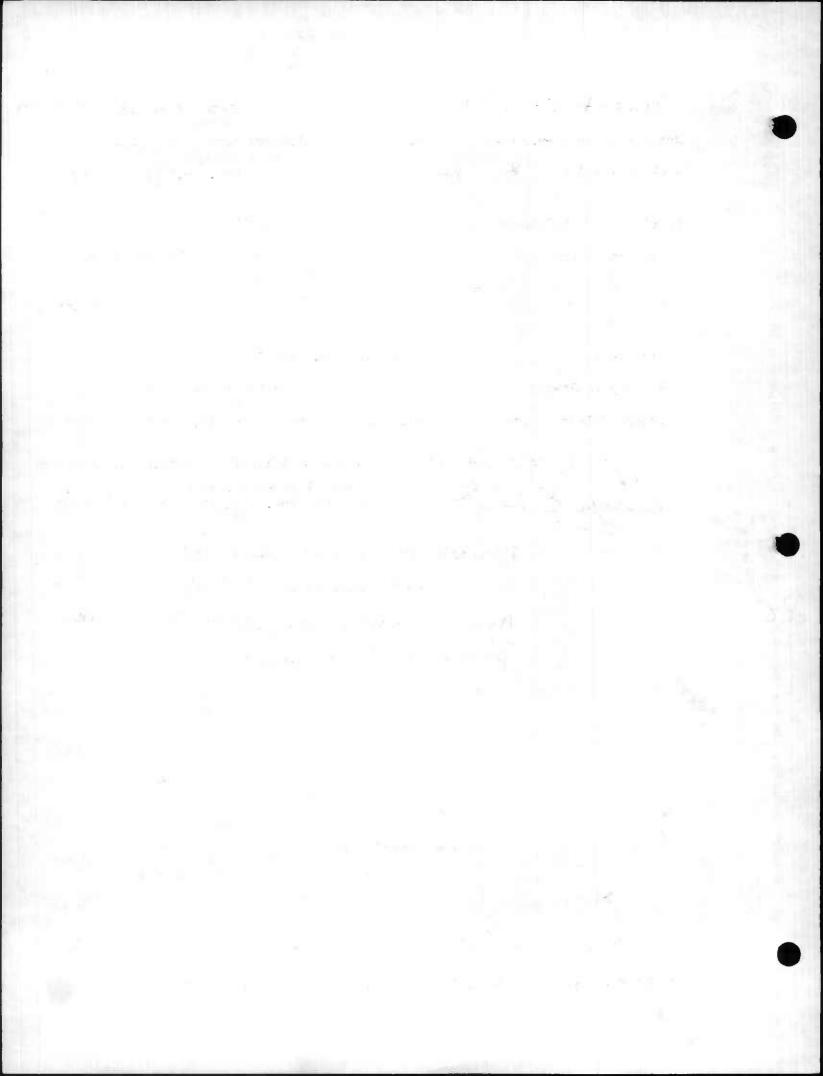
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Deeth **Physician** VICTOR 3.30 PM SHVED MARCH * /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street end number) Examiner LEVINDALE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthpiaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 18 M 2□ F Months Yrs. 79 OCT. 10,1918 UKRAINE Director 219-39-3782 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at the Maryle MARYLAND N/A BALTIMORE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 W. BELVEDERE AVE, APT. 1014 21215 UKRAINE Funeral 12. Was Decedant Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Biack, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter. Department of Health and Mentel Phytiene. If Item 27 is marked other than "natural", or ite 1 Naver Marriad 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yas 2 No Specify: by 3 Widowed 4 Divorced WHITE SHVED Completed 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) **AERONAUTICS** 5+ ENGINEER 17. Fathar's Name (First, Middle, Last)
PHEDOCY 18. Mother's Neme (First, Middle, Maiden Surneme) Be SHVED **PHEDORA PARHOMENKO** 2 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) MRS. LYUBOV SHVED (WIFE) 2500 W. BELVEDERE AVE, APT. 1014 BALTO., MD 21215 other 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State any injury or BALTIMORE HEBREW 3-9-1998 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name 301 Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208 rations that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, as cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) NEUMONIA Examiner Due to (or as a consequence of): Examiner DEMENTIA SENILE Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pue burial-trar Box 68760. physician certificate be Physician/Medical the Due to (or as a consequence of) 58 980 0 23b. Did tobacco use contribute to the cause of death? ed by the deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown P of Vital Records. 24b. Were autopsy findings availebla prior to completion of causa of death? 24e. Wes an eutopsy performed? Completed peen s hes page 2 2 DiNo 1 Yes 2 No 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27 Manner of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation Division Attending 1 Natural efter death. Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide ò 24 hours e Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and mannar stated. 29a. Certifier Medical (Check only one) To the within 2 ATTENDING 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Dev. Year) PHYSICIAN D 25610 MARCH T 30. Name and address of person who completed cause of death (item 23a) (Type, Print) SET HTWAR WEST BELVERDERE AVENUE BALTIMORY MARYLAND 21215 LEVINDALE 31. Data filed (Month, Dey, Year) 32. Registrar's Signature State to Lavidson-Randolle Registrar MAR 1 0 1998

	1)			2. Dete of Deet	-	Year	3. Time of Deeth
William Lawrence				March		98	8:55 AM
4e Facility Neme (If not institution, give		A 100 PM	4b. City, Town, or L		4c. County	of Deeth	
1815 Woodbourne 5. Social Security Number 6. Se		st birthdey) If Under 1 Year	Baltimor If Under 24 Hrs.	8. Dete of Birth (Month, Day,		9. Birthole	ace (State or Foreign
	©M 2□F 93	Yrs. Months Deys	Hours Min.	August 22	2, 1904	Mar	ece (State or Foreign
10e. State 10b. County	10c. City,	Town or Location				10	d. Inside City Limits
Maryland N/A	Balt	imore					1 X Yes 2 □ No
10e. Street end Number		10f. Zip Code		10			
1815 Woodbourne A		21239					
11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	13. Wes Decedent of If Yes, specify Cub 1 ☐ Yes 2 X No		Rican, etc.)	Blec	Citizen of Whet Count Inited Stat 14. Race - America Bleck, White, e Specify: Whit Kind of Business/Indu dighway Ma en Sumeme) eralski y or Town, State, Zip e, MD 2123 Location - City or Tow Indalk, Mai Inc. MD 21214	itc.
15. Decedent's Ed (Specify only highest grad	ucation de completed)	16e. Decedent's Usuel Occu (Give kind of work done	pation duning most of work	sina	16b. Kind of Bu	siness/Indu	ustry
Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	ed)				
17. Fether's Neme (First, Middle, Last)		Foreman	19 Mathada Nam	o /First Middle A			intenance
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19e. Informent's Neme/Reletionship (7		19b. Meiling Address (Stree					
Mrs. Anna Mary Smi		1815 Woodbour	ne Avenue				
20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐	Removel from State cerr	netery, cremetory or other ple	1				
4 Donetion 5 Other (Specify		ed Heart of Jesus				-	ryland
21. Signeture of Funerel Service Licens	Hau	5305 Harfo	rd Road	Baltimor	e, MD 2	whet Country d Stat ce-America ck, White, et w: Whit usiness/Indu ray Ma ne) ki , State, Zip C D 2123 - City or Tow k, Mar	
23a. Pert1. Enter the disease, or comp shock, or heert feilure. List only	olications thet caused the deeth.	Do not enter the mode of dy	lng, such es cardiac	or respiretory erro	est,		Approximate Interval Between Onset end Deeth
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State of Maryland / Department of Health and Mental Hygiene

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/Medica		BERTHA	SZLA	SAF					03	06	98	8110 PM
Examine	er	4a. Facility Name (If not institution,							Location of Dea	ath 4c. Coun	ty of Death	
	_	Johns Hopkins B 5. Social Security Number		dical Ct: 7. Age (In yrs. last i		If Under 1 Ye		altimon) in the	N/A	1 (0) 5
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show		10a. State 10b. County		10c. City, To	wn or Loc	cation					1	10d. Inside City Limits
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or 28a-f	lrec	10e. Street end Number				10f. Zip Coo	de	Dune	· CLA	10g. Citizen o	What Cour	ntry?
23a	alD	7468 Berkshir	e Road					2122	24	Unite	d Sta	ites
raminer m	by Funeral Director	11. Maritel Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	Armed For	2 N O		Was Decedent f Yes, specify (I ☐ Yes 2 ☐			pecify Yes or No Rican, etc.)	No- 14. Re Bi	ice - Amerk ack, White, ify:	
		15. Decedent's	Education		a. Deced	dent's Usuel Oc	ccupatio	on		16b. Kind of		
Medi	Completed	(Specify only highest Elementary/Secondery (0-12)	grade completed) College (1-	4or 5+)	(Give I	lent's Usuel Oc kind of work do DO NOT use re	one dun etired)	ring most of wo	rking			
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matic e	To	Anthony Koslo								Szymansk		
2 6		Joseph Szlasa								ber, City or Tow		
other			5011			Berksh		Road		k, Maryl		21224
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	B □Removal from S	0.000 0.0	tery, crem	natory or other	place)		Date	20c. Location	- City or To	own, Stete
any Injury or		4 ☐ Donation 5 ☑ Other (Spe			Lawr	n Mauso	leu	m 3/10	/1998	Baltim	ore.	Maryland
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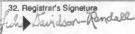


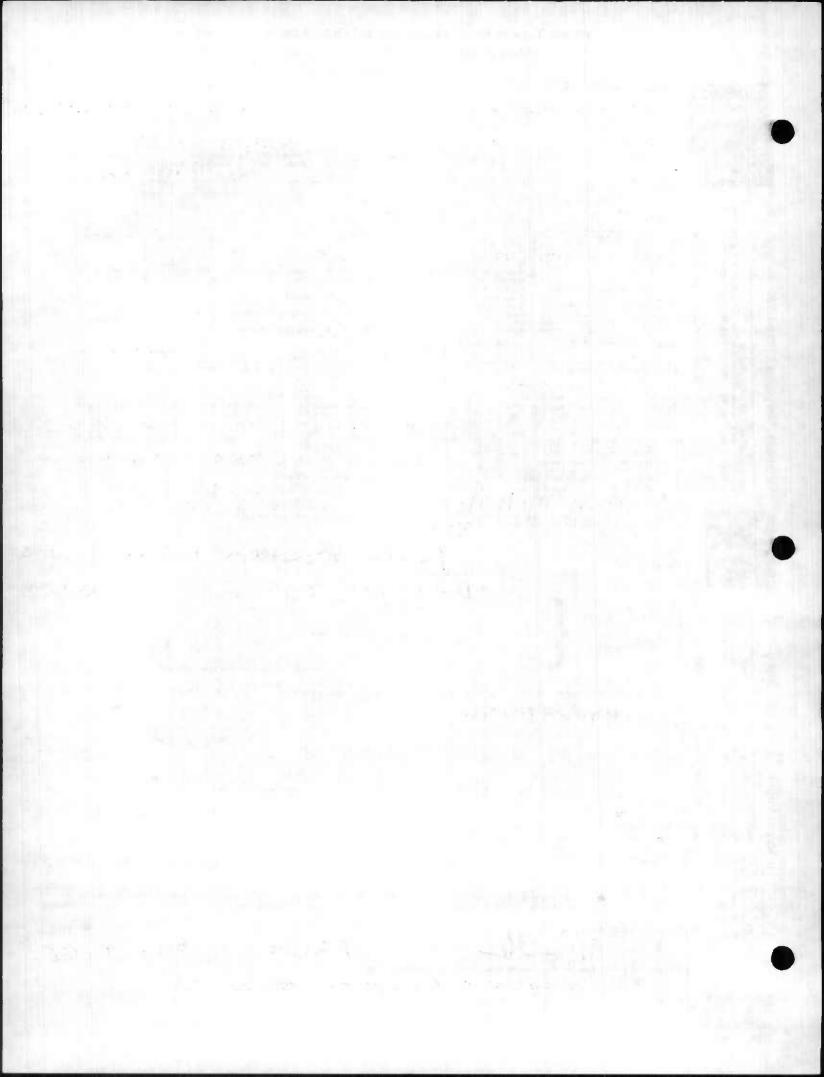
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** BETTIE HOGAN SALTZMAN 1998 March 6 11:02 p.m. /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 1305 E. Northern Parkway Baltimore If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M 2 X Yrs. 215-28-8755 68 Director Sept. 9,1929 Maryland Usuel Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside Clty Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any fujury or other treumatic event, the Medical Examine mantle and any burge. Maryland N/A Baltimore Yes 2□ No Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 1305 E. Northern Parkway 21239 U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Aq WHITE XXWidowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) Executive Secretary Human Relations 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Francis Thomas Hogan Emma Carroll 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Pnint) John J. Cain Son 33 Eastford Ct. Baltimore, Maryland 21234 20b. Piece of Disposition (Neme of cametery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Surial 2 Cremetion 3 Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Moreland Memorial Park 3/9/98 Baltimore, Maryland 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Home Inc. Dra 10 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 6500 York Rd. Balto. Md. 21212 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Flna) INFARCT MYQCARDIAC disease or condition resulting in deeth) Examiner 20 YEARH Examiner BETES physician and the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequenca of): attending pl signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown PERTENSION þ The law requires 24b. Were eutopsy findings eveilable prior to completion of cause of death? should 24e. Wes en eutopsy Completed performed? certificate has b 1 Yes 2 No 1 Tyes 2 No. Attending Physician: director, Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturei 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) or A after 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture end title of cartiff A PO 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Nathan M. Rosenblum MD 7600 Osler Drive Towson, Md. 21204 31. Dete filed (Month, Dey, Year)

State Registrar

MAR 1 0 1998





State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** GOLDIE 1998 MATILDA STENE MARCH 6, 9:45 PM /Medical 4a. Facility Nama (If not institution, give street end number) 4b. Cltv. Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 7. Aga (In yrs. last birthdey) If Under 1 Year 5. Social Security Number If Undar 24 Hrs. 9. Birthplace (Stata or Foraign Country) 1915 West Virginia 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 TF 545-20-6603 82 Director Usual Rasidance of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Director Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 6317 Banbury Road 21239 U.S.A. 12. Was Decedant Evar In U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Giva Yaar or Datas: 1 ☐ Yas 2 ☑ No þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedant's Education (Specify only highast grada complatad) 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamentary/Secondery (0-12) Collega (1-4or 5+) 8 years Owner/Operator Grocery Store 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Gaza Gillinger Ida McKinley Hensel 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Roger Gregory (nephew) 6317 Banbury Road Baltimore, Maryland 21239 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Green Mount Crematory 3-10-98 Baltimore, Maryland 21. Signatura of Funaral Sarvica Licansaa Mitchell-Wiedefeld Home, Inc. 23a. Part 1. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21212 Approximate Interval Batween Onset and Deeth **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting in daath) Examiner Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaase or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy parlomad? Completed 2 1No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical Be 26. Placa of Daath (Check only ona) axaminar? Hospital: Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1 Yas 2 No 2 1 Impatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury et Work? 28d. Dascribe how Injury occurred Certification: 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 ☐ Could not be detarmined 3 Sulcida Pleca of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homlcide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and dua to tha causa(s) and mannar as stated. Medical 2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signetura and titla of certifiar 29d. Date signed (Month, Dey, Year) 012732 30. Nema and address of person who complated cause of death (Item 23a) (Type, Print) 660 ROE A-BED ON 515 F FAIRMOUNT AND BALTO DD. 21286 32. Ragistrar's Signatura don Jondas? 31. Data filed (Month, Day, Year) State

Registrar **DHMH 16 Rev 6/95**

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death

Baltimore, Maryland 21215-0020

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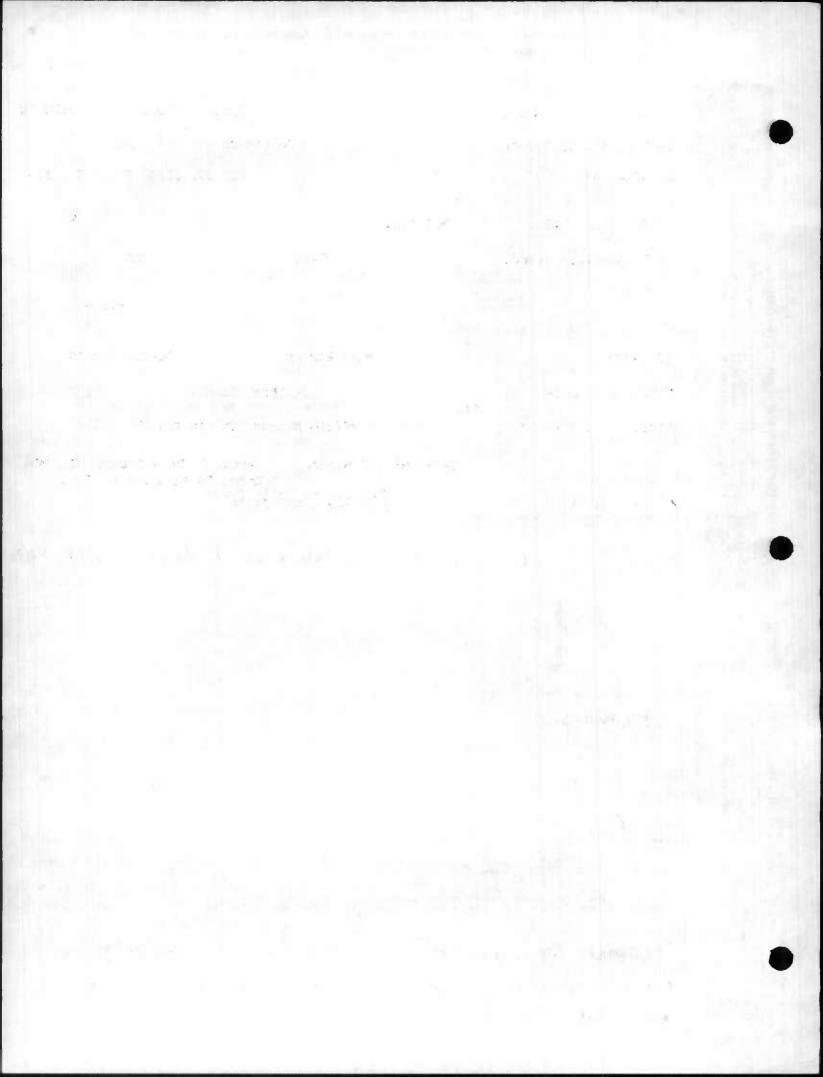
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7 is marked other than "natural", or itams 23a or 28a-f ahow traumatic evant, the Medical Examinar must be notified at

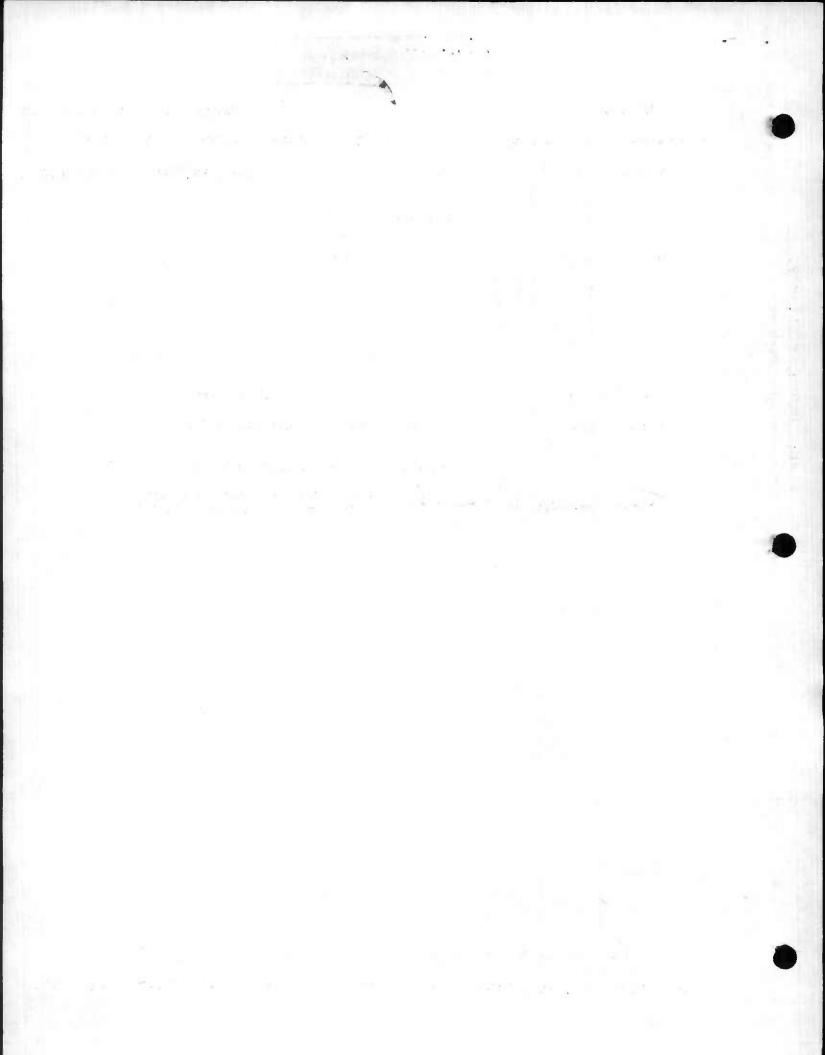
State of Maryland / Department of Health and Mental Hygiene

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Bal	Depertm Depertm Importar any injui		21. Signature of Funer	,	\sim	11	11/	22. Name end Add	Dolument F	lmoral H	iomo Inc			
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_	Dhyalaian		shock, or heert fe	eliure. List only	one ceuse on e	ech line	n, Do not e	nter the mode of t	lying, euch es cardiac	or respiratory	arrest,		Approximeta Interval Between Onset and Death	
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ta	ysician: The I is certificate he director, page	Bec	25. Wes case referred	to medical					28. Place of Deel					
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N	pital or Attending I	Certification:	3 Sulcide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)								(Street and Numi wn, State)	ber or Hura	il Houla Number,	
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	,		DR. CUSTO						RTH POIN'	T ROAD	, FORT	HOW	ARD, MD.	
)	Sta	te	31. Dete filed (Month, L	Dey, Year)		egistrer's Signal								
-1	Registr	ar	MAR 1	1998	guila	יייונות מספוייי	P. Justine							



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 5 per F.H. G-757 3/10/98 reb Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death TAORMINA BESSIE **Physician** 1.45 QN 96 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALT, MOKE

if Undar 24 Hrs. 8. Date

Min. Mon HOSD KINS BANVIEW TOD If Under 1 Yaar 8. Date of Birth Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Usual Residence of Dacedent Days Months Director permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiena. Important: if fem 27 is marked other than "betural", or items 28 or 28s-f show any injury or other traumetic event. The Maries I services. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director JI MORE 10e. Straat and Number 10g. Citizen of What Country? 10f. Zip Code 1.5.A DONNELL 21224 Funeral 12. Was Decedent Ever In U,S. Armed Forces?

1 Yes 2 No If Yes, Giva Raca - Amarican Indian, Biack, White, etc. 11. Maritai Status 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Ricen, atc.) 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No þ 3 Widowed 4 □ Divorced Specify: WHITE 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DESSIE MUIELS 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35/4 D D

20b. Place of Disposition (Nama of cemetery, grematory or other pla BALD. MD. 21224 EUGENE AORMINA Date 20a. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State Donation 5 Othar (Specify) Part 1. Enter the disease or complications that causad tha death. Do not anter the mode of dying, such as cardiac or respirator, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Cause (Final disease or condition resulting In death) Myocardia Ihr Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immadiata ceusa. Enter Underlying Cause (Disease or Injury that Initiated avants resulting in death) Last Due to (or as a consequence of) physician s the buria Records, P.O. Box 68760 Physician/Medical Dua to (or as a consaquence of): as signed by the et id be detached for Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24a. Was an autopsy 24b. Were autopsy findings available prior to complation of cause of death? been: After this cartificate 1 Yes 2 18 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attanding Physician: within 24 hours aftar death.

To the Funeral Director: After this carditica 25. Was case referred to medical examiner? Be 26. Placa of Daath (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA filled in by the funaral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifian Medical 29b. Signatura and title of certifiar 29c. Licanse number 29d. Data signed (Month, Day, Year) 30. Name and address of person who complated ceuse of death (Item 23a) (Type, Print) 3411 BANK Street S. KULATHUNGAM MD

DHMH 16 Rev 6/95

State

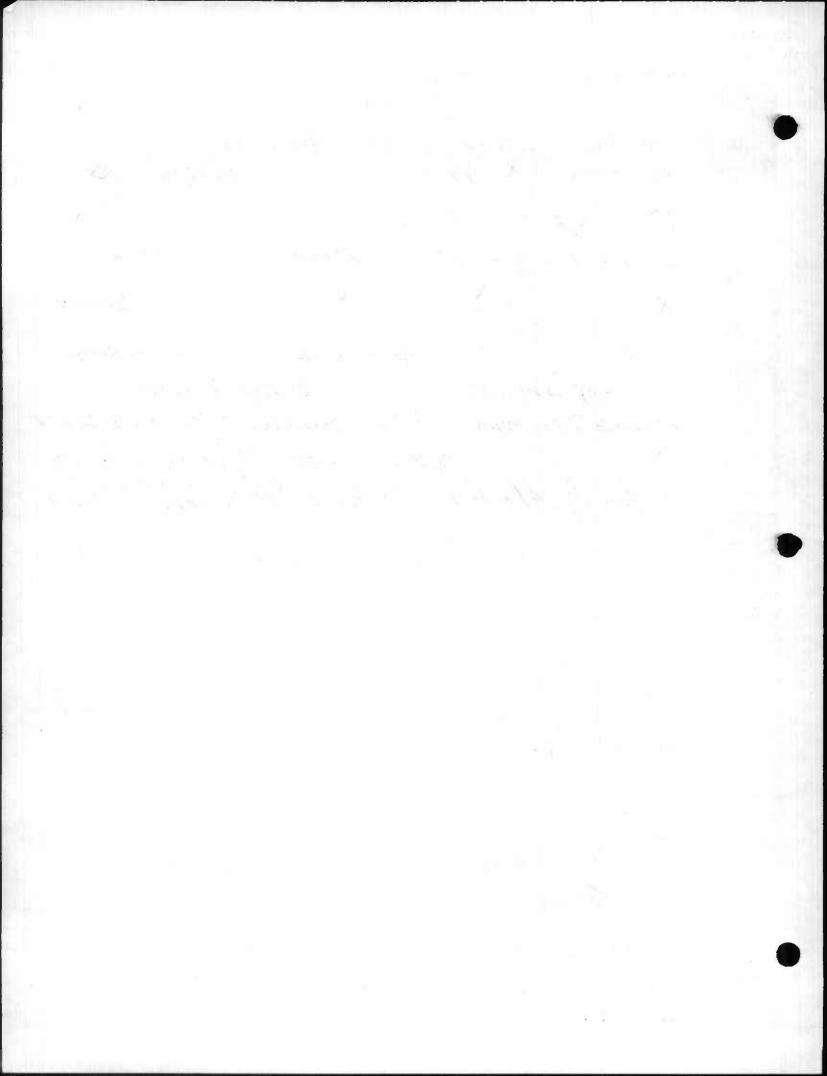
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31. Date filed (Month, Day, Yaar)

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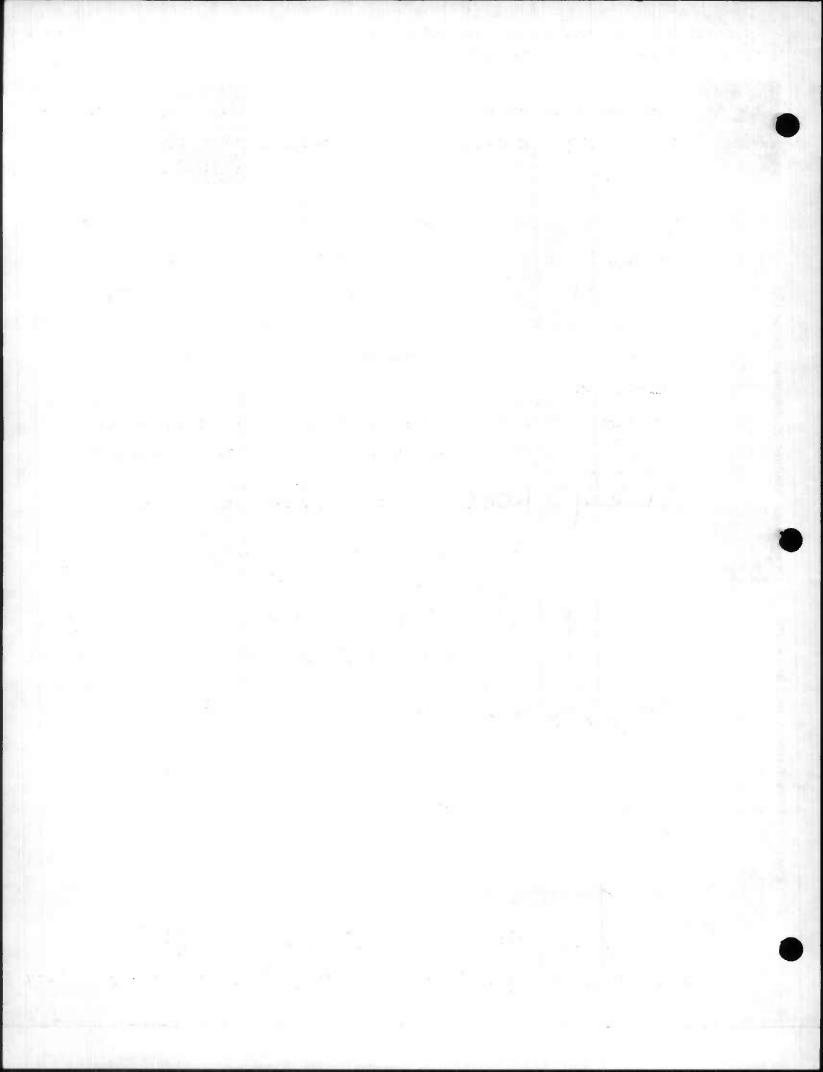
32. Appistrar's Signature

who windows - Randelle



State of Maryland / Department of Health and Mental Hygiene

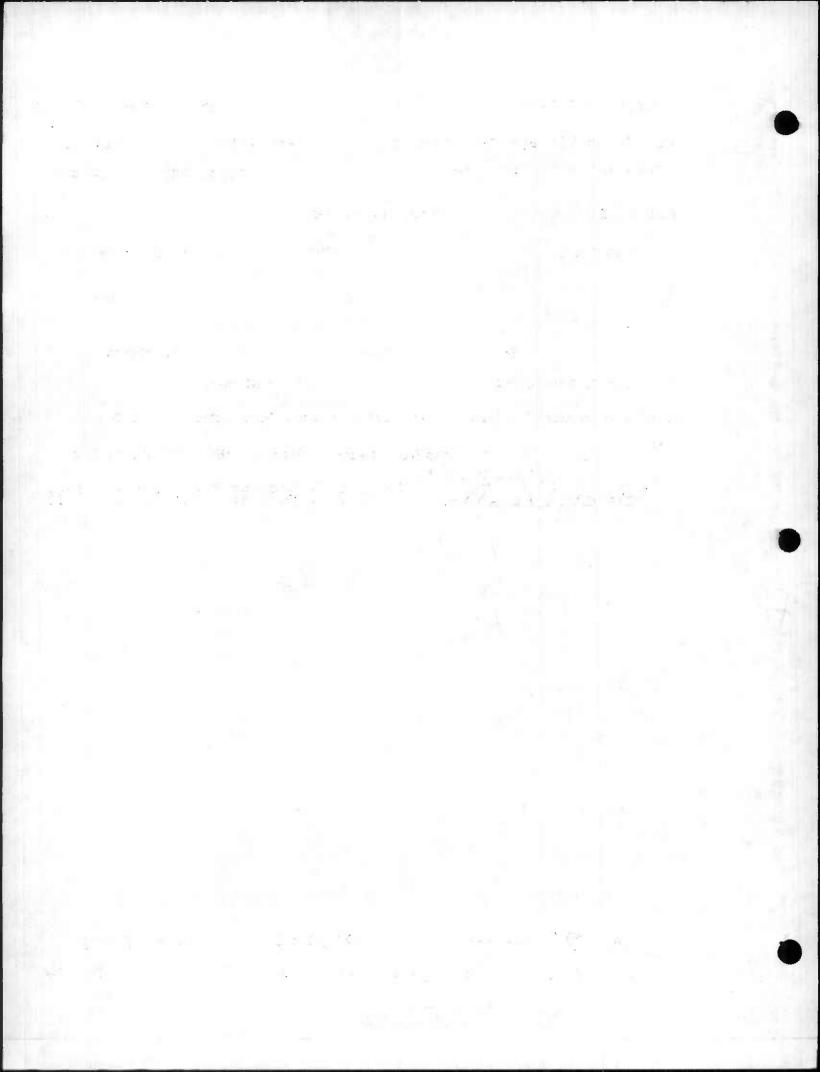
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tem 27 is marked other then other treumatic event, the M To Be Comp	2	Roland Lee Mi	11s										
E E		19a. informant's Name/Ralations			19b. Mailin	ng Addras	s (Street	and Number	or Rural Routa N	umber,	City or Town,	Stata, Zip Code	1)
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lury	-	4 Donation 5 Other (S	pecify)	Met	ro Cre				03/06	E	saltimo	ore, MD	
Important: any injury ance.		21. Signature of Furnaral Service	~ ()		Ţ	Jarde	otto	ss of Facility	1 Home,	D A			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

	1. Decedent's Name (/	First, Middle, La	st)			cate of l		2. Date of D			3. Time of Death											
an al	Maurya	F. Til	lery					March	6, Day 19	98	7:10pm											
ner	4e. Facility Neme (If no	ot institution, giv	e street end number))		4	b. City, Town, or	Location of Dea	th 4c. County	y of Deeth												
	5. Social Security Num 214-40-418	6. S 85	lage Car	e Cel ge (In yrs. Ias 84	st birthday) if U	Inder 1 Year oths Days	Parkv if Under 24 Hrs Hours Min.	8. Date of Bi	rth ay, Year)	Baltir 9. Birthplace Country) Mary	e (State or Foreign											
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tor	Maryland 1	Baltimo	re	Ti	monium,	Maryla	and				1 □ Yes 2016io											
Direc	10e. Street and Number				101	f. Zip Code			10g. Citizen of													
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by Funeral Director	11. Maritai Status 1 ☐ Never Married 3 □ XWidowed 4 □		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	7		specify Cube	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)	Specify	ce - American ck, White, etc. y: Whit												
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To	Theodore	J. Roga	atchoff				Tina	Slucero	J													
	19e. Informant's Name David R. Mo			4	19b. Mailing Add 622 hast		and Number or Ru			Stete, Zip Co 21286	de)											
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	1 2 Durial 2 □ C 4 □ Donetion 5 □		Removal from State		Hill Ceme			1, 1998	Baltimore	e, Maryla	and											
	21. Signature of Funer	rai Service Licen	see Victor P.	Doda,J	Char	e and Addres	. Stev	ens Fu	neraļ 1	Home,	Inc.											
	23a. Part1. Enter the d shock, or heart fa	disease, or comp	plications that caused	d the death.	Do not enter the	1 Eas	t Fort	Ave.	Baltimo		proximate ervel Between											
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physicien: 24 hours after death.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. and title of certified 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E MARCH 6, 1998 and address of person who completed cause of death (Item 23a) (Type, Print) ackt NG 111 Penn Street, Baltimore, Maryland 21201 32. Registrate Signature

Julia Davidson Randell 31. Date filed (Month, Day, Year)

Registrar

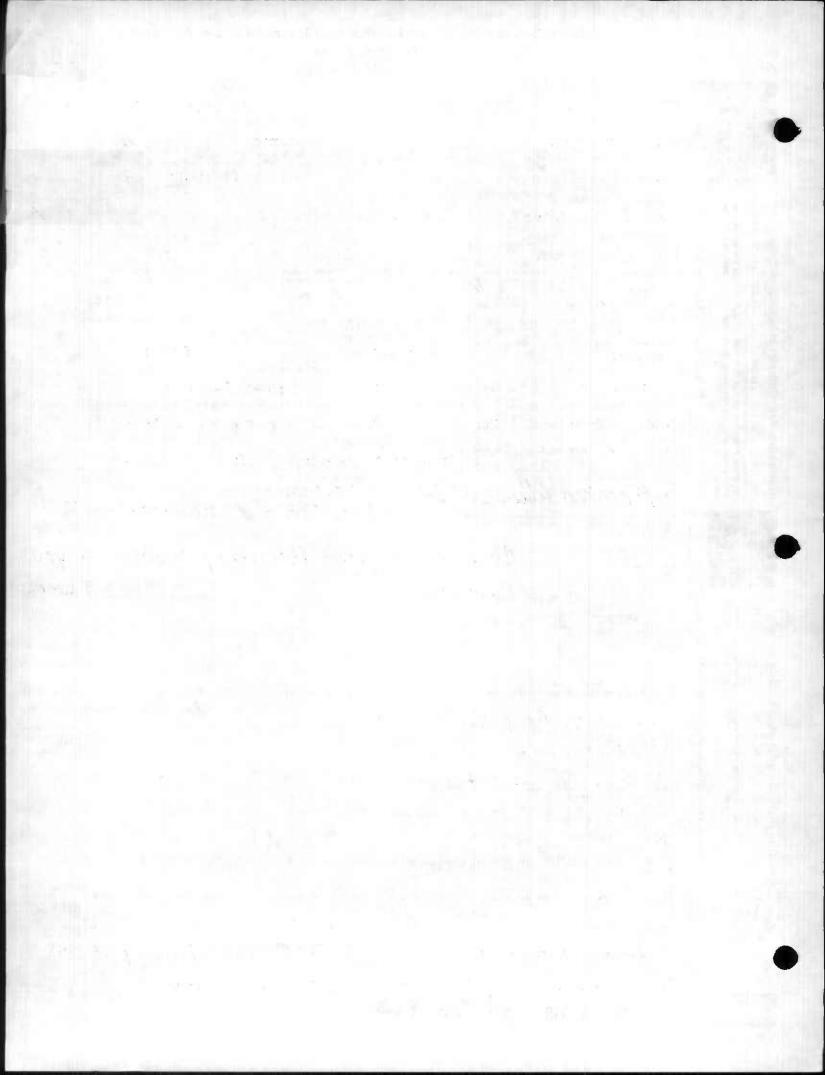
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30. Nama and addrass of person who compiated causa of death (Itam 23a) (Type, Print) NORTHWEST HOSPITAL CENTER 5401 OLD COURT RD. RANDALLS	

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Examiner		MARINER HEALT			im <i>oer)</i>				EL AIR		Dation of Dati		FORD	
Funeral Director		5. Sociel Security Number 109–26–6690 Usuel Rasidance of Decedent	8. Sa 1	ax □M 25x F	7. Age (In yrs. 93	last birtho	Months	1 Yeer Deys	If Under 24 Hours	4 Hrs. Min.	8. Date of Birt (Month, De MARCH	16,1904	9. Birthp Coun NE	lece (Stete or Fo
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Department of Heelth end Mental Hyg Important: If Item 27 is marked other any Injury or other treumatic event, angle. To Re C		19e. Informent's Name/Ralation MRS. ZITA SC		**	GHTER)							er, City or Town, MD 21(Coda)
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State Registrar

31. Data filed (Month, Dey, Yaer)

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Item: 19a PER FH Film G-757 3-10-98RC Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Death Month **Physician** MA 1998 /Medical 4b City, Town, or Location of Death 4e. Facility Name (If not institution, give street end number) West Belvede 4c. County of Death Examiner BAHmore sital of Bult, more
If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday). **Funeral** Deys Months Min. 578-03-0912 10 M 25 F 86 Yrs. WASHINGTON, D.C. Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MARYLAND BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Itama 23a or 3528 CABOT ROAD 21133 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bieck, White, etc. 11. Marital Stetus 1 end 2 should be filed within 72 hours efter Heelth end Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 21215-0020 1□ Yes 2↓No Specify. þ 3 ☐ Widowed 4 ☐ Divorced should be mo-and Mental Hygiene. s marked other than "natural" WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be SAMUEL FRANKEL BROWNSTEIN YETTA traumatic 19a. informant's Name/Belationship (Type, Print)
MR. HARCE WEITZ (HUSBAND) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Heelth em 27 ls 3528 CABOT ROAD RANDALLSTOWN, MD 21133 item 2 other 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Peges ō 1 Burial 2 □ Cremetion 3 □ Removal from State = 0 Department If Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH -3-5-1998 BALTIMORE, MD 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD 21208 ter the sease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, heart failure. List only one cause on each line. Physician fmmediate Ceuse (Final disease or condition resulting in death) /Medical Examiner burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Lest Box 68760. Completed by Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown Records, 24b. Were autopsy tindings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 PInpatient 2 □ ER/Outpetient 3 □ DOA this funeral 28a. Dete of injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After Division 5 Pending investigation 1 Naturel 1 Yes 2 No death. 2 Accident ofter death Director: A 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide pelli 24 hours Hospital 29a, Certifier 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end placa, end due to the ceuse(s) and menner es stated. Medical pletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) end manner steted. within 2 To the I ŝ 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 0 erson who completed cause of death (Item 23e) (Type, Print) 31. Date filed (Month, Dey, Year) 24010 State Registrar 0

4. 参

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth **Physician** WEBB WILLIAM 0102 am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner GIEN BURNIE DRTH ARUNDEL HOSPITAL COUNTY If Undar 24 Hrs. 8. Date of Birth (Month, Dey, If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sax **Funeral** 1 XM 2 □ F Months Days 212-24-5406 Yrs. 70 Director Maryland Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene.

Int: If Itam 27 is marked other than "naturel; or items 23s or 28s-1 show ary or other traumetic event, the Medical Examiner must be nothed at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. Hygiene. other than "naturel", or Heme 23a or 28a-1 ehow rent, the Madical Examiner must be nothing at MD 1 ☐ Yes 2 ☑ No Howard Director Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6985 Dorsey Road 21075 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☑ Yas 2 □ No If Yes, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Navar Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dietary Manager Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumame) UNK. 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Ann Webb/Wife 6985 Dorsey Road Elkridge, MD 21075 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata permit. Page Department or Important: If any injury or once. Metro Crematory, Inc. 03/10/93 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Cremation Society of MD, Inc. 21. Signature of Funeral Service Liptinger 299 Frederick Rd. Baltimore, Edward A. Gregorchik 21228 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Approximate interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Due to (or es a consequence of): Examiner siclan end bunel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 98 usa Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Millit 2 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Menner of Death Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 2 28e. Dete of Injury (Month, Day Year) funeral 28h Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide

that the death certificate be exec physician s the burie Box 68760. P.0. been signed by the should be datached Division of Vital Records, page 2 certificate Physician: Attending Hospital of Attending
 24 hours after death.
 Funeral Director: After To the I within 2 To the I complet

Baltimore, Maryland 21215-0020

State Registrar

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31. Date filed (Month, Day, Yeer)

29b. Signature and title of certifier

29a. Certifier

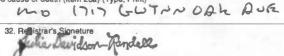
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JAMES

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30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)



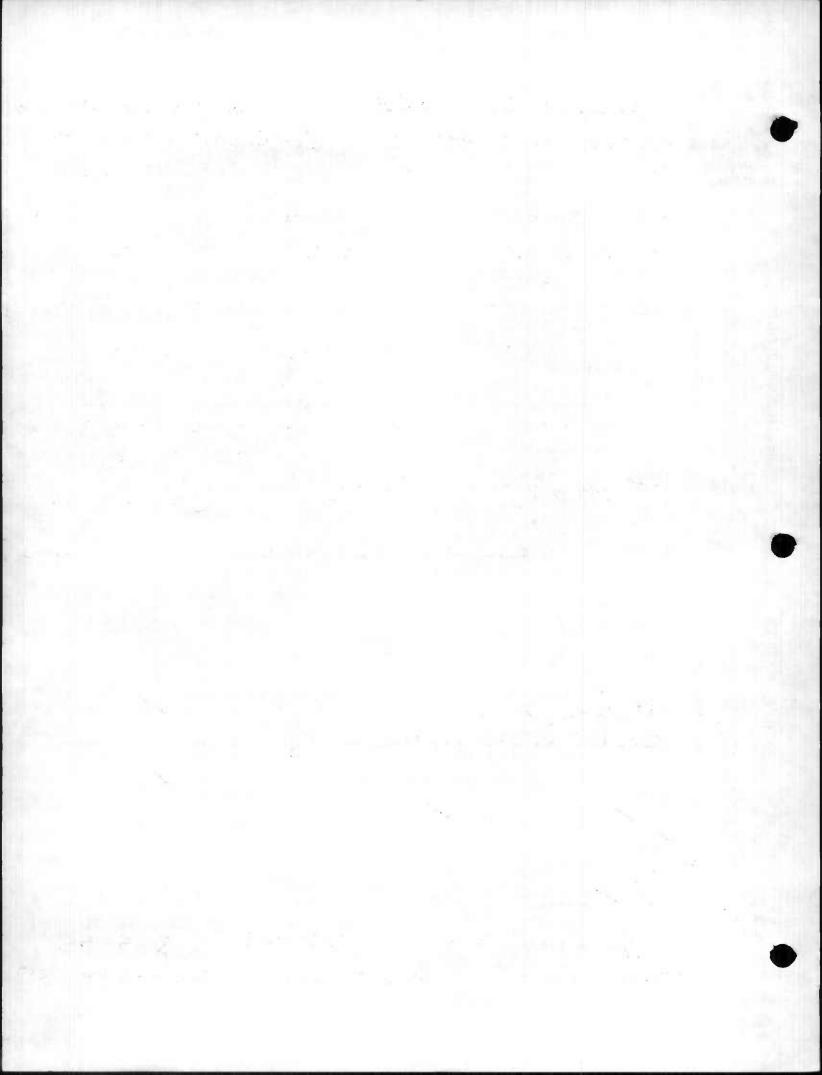
Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the cause(s) and manner steted.

29c. License number D34908

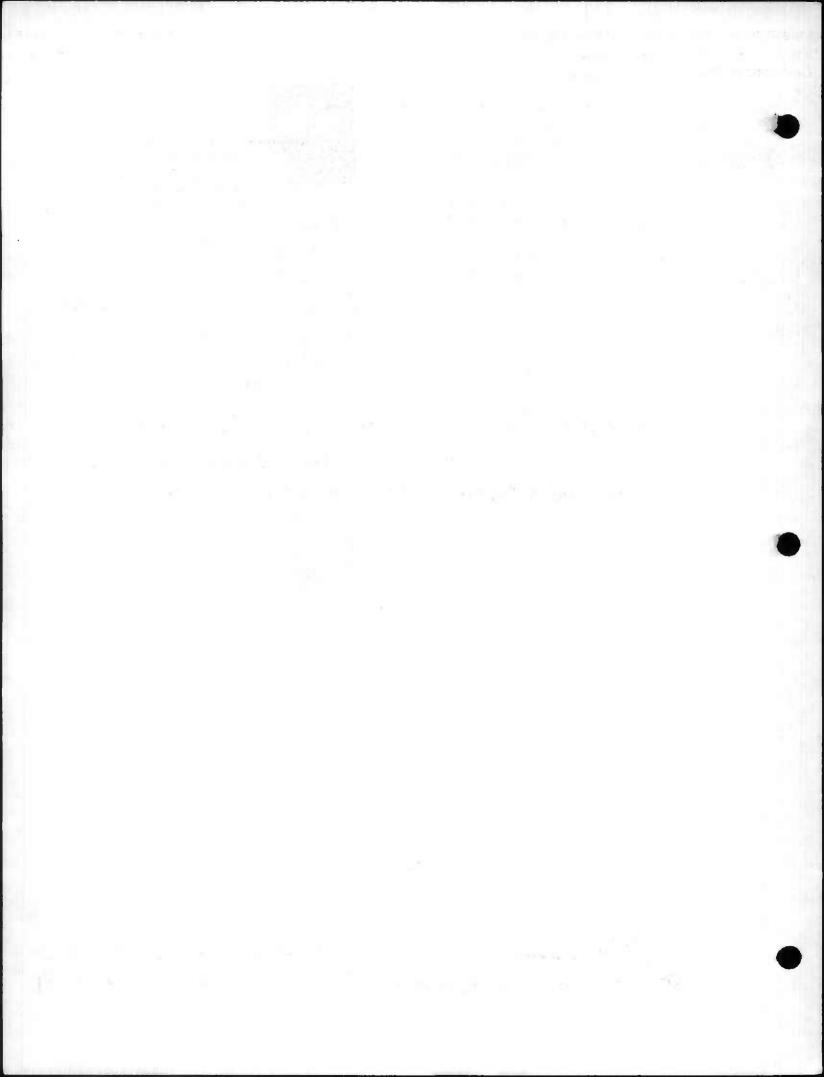
29d. Date signad (Month, Day, Year)

BACTIMORE MO



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Certifica	ate of	Death	F	leg. No.	8 (174	95
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020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or itema 23a or 28a-f ahow brt, the Mocietal Exercises must be notified at	by Funeral Director	11. Maritel Stetus 1 □ Navar Marriad 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant Armed Forces? 1 Yas 2 If Yas, Giva				tispenic Origin? (Sp an, Maxican, Puerto Specify:	ecify Yas or No- Rican, etc.)	14. Rec Bled Specify	e - Amaric ck, Whita, a		
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T	Physician										Į Į	Onset and	Death
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Manth J /Medical 4a., Facility Nama (if not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** BAHIMORE 1EdICA If Undar 24 Hrs. 8. Data of Birth Hours Min. Month, Day, 5. Social Sacurity Number If Undar 1 Yaar 6 Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) **Funeral** Months 1□M 2XF Days 220-80-497 32 Yrs. Director 10a. Stata 10b. County 10c, City, Town or Location r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 XYas 2 No Director NA AltImore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21215 12. Was Dacedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 No If Yas, Give Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 11. Marital Status 14. Race - Amarican Indian Black, Whita, atc. filed within 72 hours efter 1 Nevar Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 Ho Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: BIACK "naturel" 15. Decedant's Educetion (Specify only highest grade completed) 16a. Dacedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working life. DO NOT usa retired) I Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) NIA other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan, Sumama) Pages 1 end 2 should be nent of Health and Mentel ant: If Item 27 is marked o Edward WATIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) SIMONE Balto BROWN-COUSIN Hilton Rd 4048 other Baltimore, 20b. Place of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata permit. Pages Department of Important: If it any Injury or of 1 Burial 2 □ Cramation 3 □ Ramoval from State 3/12/98 BAltimore, MD 4 ☐ Donation 5 ☐ Othar (Spacify) EMETERY 21. Signatura of Funaral Sarvica Line 22. Nama and Addrass of Facility Home MARCH Wm WADASH AUE, BAITO MD 4300 23a. Part I. Entar the disaasa, or complications that ceusad the death. Do not antar the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onsat and Daath **Physician** Immediate Causa (Finat disease or condition resulting In death) /Medical deficiency syndione **Examiner** Dua to (or as a consaquance of): Physician/Medical Examiner PNEUMONK Catinii neumocustis the buriel-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or Injury that initiated events rasuiting in daath) Last Dua to (qr as a consequence of): espiraturu Box 68760; Failure physician 2 Dua to (or as a consequence of) The lew requires that the death certificete Endo cardutos use as Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Gastro Intertual 1 Yee 2 No 3 Probably WUnknown þ 24b. Were autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy Hyper tension performed? certificate hes Intravenous Drug ABUSE t □ Yas B No 1 Tas Physician: director. 25. Was casa rafarrad to madical axaminer? Be 26. Placa of Death (Check only ona) 1□ Yes 2□ No Hospitat: Other: 4 Nursing Homa Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 5 ☐ Rasidance 6 ☐ Othar (Specify) this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Daath 1 Naturat 2 Accidant 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending Investigation or Attending death. 1 Tyes 2 No efter death completely filled in by the 6 Could not be datermined 3 Sulcida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rurai Routa Number, City or Town, Stata) To the Hospital within 24 hours e To the Funeral D Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and titla of certifiar 29d. Data signed (Month, Day, Year) name m.O enance 37203 30. Nama and address of parson who complated ceusa of death (Item 23a) (Type, Print) medical Onty Baltimore Md 21215 Suberty

32. Registrar's Signatura

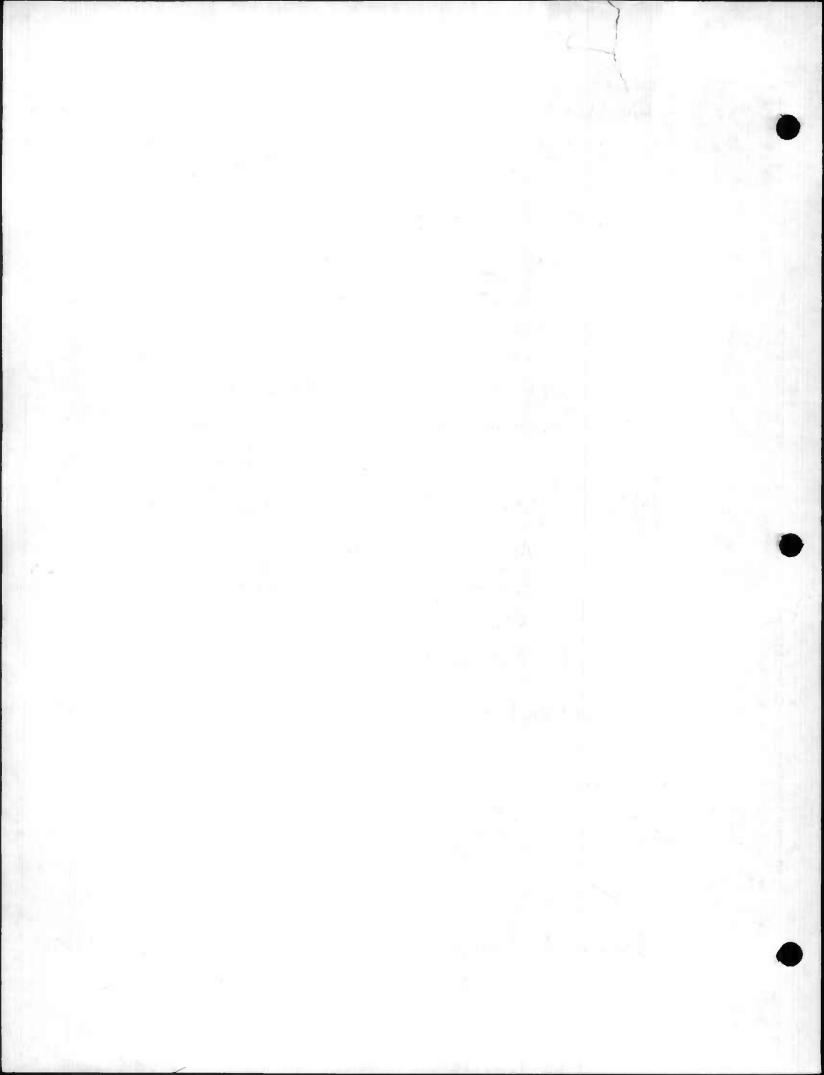
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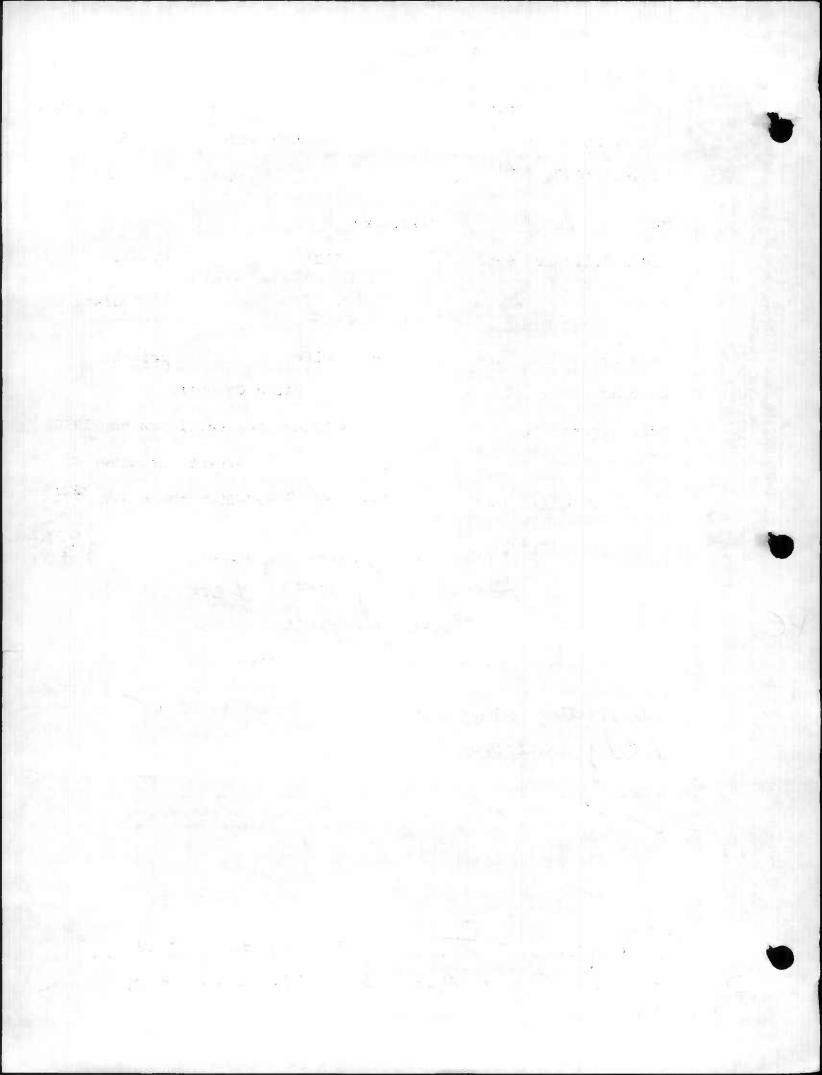
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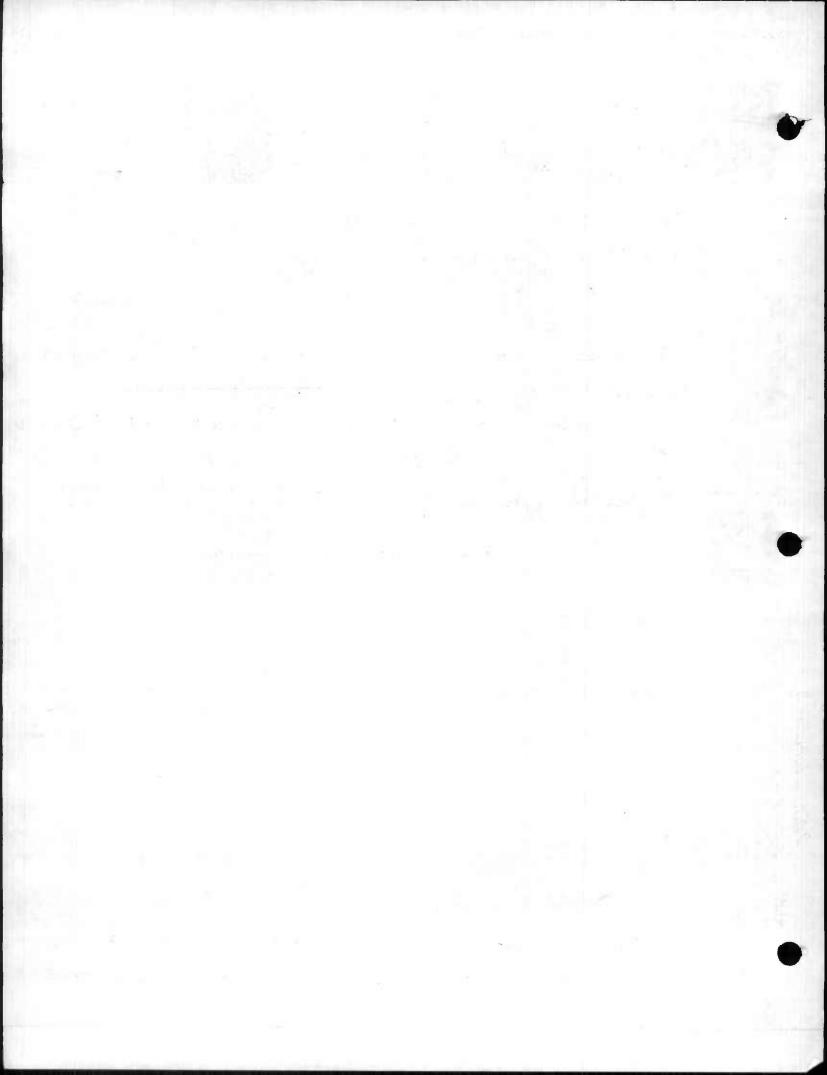


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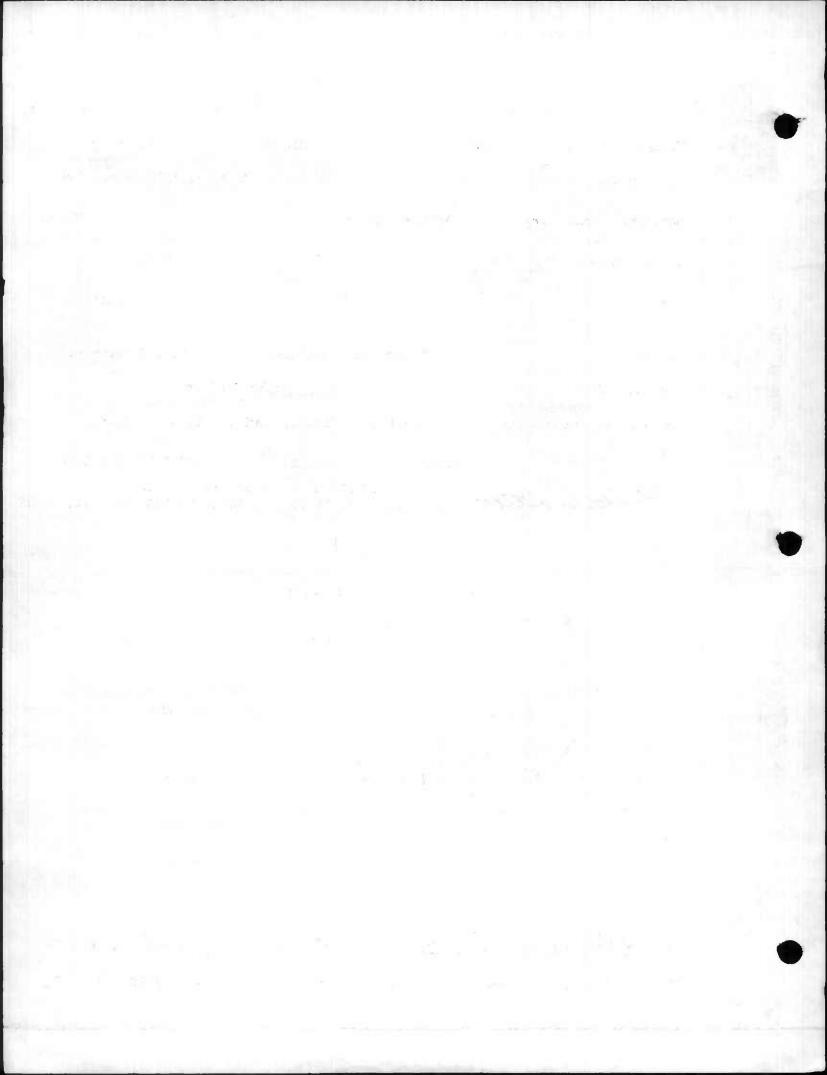
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Item: 9 per FH G-757 3/25/98 dh Certificate of Death Item#1.18 per FH G757 3/24/98 EW 2. Data of Daath 3 Time of Death 1. Decedant's Nama (First, Middla, Last) **Physician** WALLACE PAUL MARCH 1998 7:32 P.M. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street and number) 4c. County of Death Examiner BAITIMORE If Undar 24 Hrs. 8. Data of B FIGNES HOSP 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Sacurity Number Birthplaca (Stata or Foraign Country)
 S.C. 7. Aga (In yrs. last birthday) 6. Sex 12 M 2□ F **Funeral** 69 Hours Months Days 251-20-9083 Usual Rasidanca of Decadant Yrs. Director with the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Manical Examinal must be notified at 1 Yas 2 No SAltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3 21223

13. Was Decedant of Hispanic Origin? (Specify Yas or Nolf Yas, specify Cuban, Maxican, Puarto Rican, atc.) HUE Funeral ION death 12. Was Decedant Evar In U,S. Armed Forcas? 1 M Yas 2 No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours efter Department of Mealth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or ite 1 Nevar Married 2 Married Maryland 21215-0020 1 Yas 2 No Specify: Specify: þ BLAC 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) SANITATION EN UTRON MENTAL NIA RIVER GEADE 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Father's Nama (First, Middla, Last) + Louise Lawson JAI 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) SON BAITO TOORES WALLACE UN other laltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition any Injury or o 1 Burial 2 Cramation 3 Ramoval from Stata 3-12-98 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Spacify) TORESI 22. Nama and Address of Facility
Wm C MARCH 21. Signatura of Funaral Sarvica Licen FUNCENI HOMES AUE, BAITO MD WADASH 4300 23a. Part1. Enter the disease, or complications that caused the death. Bo not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata intarvai Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical ACUTE MYOCARDIA IN FARCITON **Examiner** Dua to (or as a consequence of) Examiner physician and the buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or Injury that initiated avants rasulting in daath) Lasf Dua to (or as a consequence of) NAME Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequanca of) 88 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. 3 Probably 45 Unknown 1 Tyes 2 No þ 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy parformad? page 2 should Completed After this certificata has 200 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to madical axaminar? Be 26. Placa of Daath (Check only ona) Hospitai: Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Yas 2 No 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funaral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 5 Panding invastigation **Naturai** 1 ☐ Yas 2 ☐ No death. 2 Accidant 24 hours after deat Funeral Director: 6 Could not be datarmined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida the Hospital 29a. Cartifiar 🕾 Certifying Phyaician: To tha best of my knowladga, daath occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signatura and tifla of certifian 29d. Data signed (Month, Day, Year) 29c. Licansa number 00051865 March 7, 1998 30. Nama and addrass of person who compiated cause of death (Itam 23a) (Type, Print) MUSPITAL, BALTIMORE AGNES CHMELES CURTIS mo 82/Ragintraris Signature and section 31. Data filad (Month, Day, Year) 01998 MAR 1 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of h	viai yiai		rtificate of			Reg. No.	0 7	1499
	Physic /Medi		Decedent's Neme (First, Middle, I DAVID	Last) WEINER					2. Date of Dee Month March 4	Dey	Yeer	3. Time of Deeth 10:40 A.M.
	Exami		4e. Fecility Neme (If not Institution, g		r)			4b. City, Town, or	Location of Deeth			20110 11111
	Funerai Director		Montgomery Gener 5. Social Security Number 6. 576-22-6149 Usuel Residence of Decedent			last birthdey,	If Under 1 Year Months Days			n /, Year)	9. Birthple Count Penn	y ece (Stete or Foreign ry) sylvania
	pue *		Usuel Residence of Decedent 10a. State 10b. County		10c Cit	y. Town or L	ocation					
	with the Meryland a or 28a-f show Lbs not fied at	o	Maryland Montgo	moru			Spring				10	d. Inside City Limits 1 XYes 2 No
	1984 1011	rect	10e. Street and Number	mer y	J.	LIVEL	10f. Zip Code			10g. Citizen of	Whet Count	
	23a or	al D	14400 Homecrest	Pood Ant	3/4		2090	16		U.S.A.		
020	or items	by Funeral Director	11. Maritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Deceder Armed Forces	nt Ever in U s? &No		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🕱 No	Hispanic Origin? (S en, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Red	ce - America ck, White, e	tc.
21215-0020	"nat	Completed	15. Decedent's (Specify only highest of Elementery/Secondary (0-12) 12 Years	Education trade completed) College (1-4o	r 5+)	(Give	dent's Usuel Occup kind of work done DO NOT use retire ronic Tec	during most of wo	rking	16b. Kind of B		
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/lan	Aental Aental rked tic ev	To B	Barnett Weiner					Mol1	y Goldbe	rg		
Maryland	end N		19a. Informent's Neme/Reletionship	(Type, Print)		19b. Meili	ng Address (Stree	end Number or R	ural Route Numbe	r, City or Town,	State, Zip	Code)
2	end lealth m 27		Benjamin H. Weir	ner, Son			Athens C	ircle, Bo		-	20716	
Baltimore,	If ite		20e. Method of Disposition 1 ☑ Burlel 2 ☐ Cremetion 3	☐Removel from State		amatani ara	osition (Neme of matory or other ple	3/06/1	Dete	20c. Location -	City or Tov	vn, Stete
Him	it. Peritmer		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Mon		banon Cer		. 550	Adelphi	, Mar	yland
Ba	permit. Peges 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic av once.		Vonald C.	1-	teme	S	2. Name end Addre TEIN HEBI 32 CARRO	REW MEMOR				D.C. 20012
	Physician /Medical Examiner		23e. Pert1. Enter the disease, or co shock, or heert failure. List on Immediate Cause (Final disease or condition resulting in deeth)	· Cor	Pue to (o	L MC)NALE quence of):		c or respiretory en	rest,		Approximele Interval Between Onset end Deeth 3 months
1	bet isi	nlne		b. Mita	ral	Rec	que gita	ction				3 years
,	execu n end iei-tre	Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	T. 1		-					i	~
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Vit	Physician: The law r this certificate hes t rail director, page 2 s	Be	25. Was case referred to medical exeminer?	Hospital:	~		0	hor	eth (Check only or			
of	> 00 0	. To	1 ☐ Yes 2/24-No 27. Menner of Deeth	1 (25Unpat	117	ER/Outpeties 28b. Time of	IL SLI DOA	4 LI Nursing F	lome 5 ☐ Resid			
vision of Vital	Attending or deeth.	atlor	1 Naturel 5 ☐ Pending 2 ☐ Accident investigeti	28e. Dete of In (Month, D	ey Year)	Injury	Wo	rk? Yes 2 □ No		,,		
Divis	Hours of Attending Ph 24 hours after deeth. Commercial Director: After thi letely filled in by the funeral	Certification:	3 Sulcide 6 Could not determine	A 286. Piece of it	njury - At ho	ome, ferm, st	reet, fectory, office		28f. Location (S City or Tow		er or Rural	Route Number,
R	n 24 hou Function	Medical	29a. Certifier (Check only one) 1 Certifying F	hysicien: To the best aminer: On the basis and menner s	of examine	wledge, deet tion end/or In	h occurred et the ti vestigetion, in my o	me, dete end plece ppinion, deeth occu	e, end due to the curred et the time, d	euse(s) end me lete and plece,	enner es ste and due to t	ited. the cause(a)
-	To the To the Comple	Σ	29b. Signeture end title of certifier				29c. Licens			29d. Date signe		
			30. Neme and address of person who	completed cause of	deeth (Item	23e) (Type.		35045		March	- 4,	1998
			PHIL HENJUM,				OD Cou	RT #20	DO OLN	EY, M	DZ	20832
	Sta	_	31. Date filed (Month, Day Year)		ver's Signa							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** CARA M. Wunder 4e Facility Name (If not Institution, give street and number) ARA 10:25 RM L March 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner RAITIMORE

If Under 24 Hrs. | 8. Dete of Birth
Hours | Min. (Month, Dey, Yeer) (Month, Dey, Yeer)

TUL. 12, 1910 | MARYLAND SAINT ELIZABETH NURSING HOME If Under 1 Year 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign 5. Social Security Number **Funeral** 1 M 2 F Months Days 220-09-5388 87 Yrs Director Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 28a-f show rai", or items 23a or 28a-f shor Examiner must be notified at 1 Yes 2 No Director MARYT AND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1415 KIRKWOOD ROAD 21207 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Race - American Indian, Bieck, White, etc. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 □ Nevar Married 2 □ Married Specify: WHITE Maryland 21215-0020 1 ☐ Yes 2 No Specify: p 3 ☐ Widowed 4 NDivorcad "natural". Completed traumatic event, the Medical 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hygiene. 7 is merked other than "na Elementary/Secondary (0-12) College (1-4or 5+) ANSWERING SERVICE OWNER TELEPHONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be 2 WILLIAM HEMLER ANNA THOMEY 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 st Department of Health and Important: If Itam 27 is n eny injury or other traun 7 MOREHOUSE LANE, NORWALK, CONNECTICUT 06850 WILLIAM E. WUNDER, SON Saltimore, 20b. Pleca of Disposition (Neme of cemetery, crematory or other placa) 20e. Mathod of Disposition Deta 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State NEW CATHEDRAL CEMETERY 3/7/98 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) WITZKE FUNERAL HOMES, INC. 22. Name end Address of Fecility 21. Signeture of Funerel Sarvice Line 1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228 23a. Pert1. Enter the disease or complication and caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceed on each line. Approximate Intarval Batwean Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in deeth) /Medical NATRICEED Commune Examiner Due to (or es e consequenca of) Examiner ician and bunial-trans Sequentially list conditions, if eny, laeding to immediate cause. Enter Underlying Ceuse (Diseese or injury Due to (or as e consequenca of) Box 68760, attending physician for use es the buria 90 Physician/Medical thet initieted events resulting in death) Last Due to (or es e consequença of) Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tohacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown yd bengis Division of Vital Records, þ 24b. Were eutopsy tindings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed peen 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes case raferred to medical exeminar? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After To the Hospital of Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Netural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homlcida 1 Certifying Physician: To the best of my knowledga, daeth occurred at tha tima, deta end plece, end due to the cause(s) and mennar as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. (Check only one) 29d. Deta signed (Month, Dey, Year) 29b. Signature and title of centiller Rullak 208780 Laureno 405 Frederick Rd Baltime 21228 30. Name and address of parson who complated cause of deeth (Item, 23e) (Type, Print),

State Registrar

ALE 31. Dete filed (Month, Day, Year)

(ANDRO

ME 114 32. Registrar's Signature ha Devidson Abadelle

